**Illinois HIPPA Privacy Notice Form**

This notice describes how psychological and medical information about you may be used and disclosed.

**I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

GRH Consulting, LLC may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

**-"PHI"** refers to the information in your health record that could identify you.

-**Treatment, Payment and Health Care Operations"**

**-Treatment** is the provision, coordination, or management of your health care and other services related to your health care. An example of treatment is my consulting with another health care provider, such as your family physician, your psychiatrist, or other therapist.

**-Payment** is obtaining reimbursement for your health care. Examples of payment are when your PHI is disclosed to your health insurer to obtain reimbursement for your health care or to determine eligibility for coverage.

**-Health care Operations** are activities that relate to the performance and operation for the practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, as well as case management and care coordination.

**-"Use"** applies only to activities within the practice such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.

**-"Disclosure"** applies to activities outside of the practice such as releasing, transferring, or providing access to information about you to other parties.

**-"Authorization"** is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a legally required form.

**II. Other Uses and Disclosures Requiring Authorization**

GRH Consulting, LLC may disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when GRH Consulting, LLC is asked for information outside of treatment, payment, or health care operations, an authorization will be obtained from you prior to releasing the information. Authorization will also need to be obtained before releasing your Psychotherapy Notes. *"Psychotherapy Notes"* are notes made about our conversation during a counseling session, which are kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations of PHI at any time, provided such revocation is in writing. You may not revoke an authorization to the extent that 1) GRH Consulting, LLC has relied on that authorization; or, 2) If the authorization was obtained as a condition of obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

**III. Uses and Disclosures Without Authorization**

GRH Consulting, LLC may use of disclose PHI without your consent or authorization in the following circumstances:

-Child Abuse – If I have reasonable cause to believe a child known to me in my professional capacity may be an abused or neglected child, I must report this belief to the appropriate authorities.

-Adult and Domestic Abuse – If I have reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, I must report this belief to the proper authorities.

-Health Oversight Activities – I may disclose PHI regarding you to a health oversight agency for oversight activities authorized by law, including licensure and disciplinary actions.

-Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis, and treatment, and the records thereof, such information is privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated by a third party or when the evaluation is court ordered. You must be informed in advance is this is the case.

-Serious Threat to Health or Safety – If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is a clear, imminent risk of physical or mental injury being inflicted against another individual, I make disclosures believed to be necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures considered necessary to protect you from harm.
-Worker's Compensation – I may disclose PHI regarding you as authorized by and to the extent necessary to comply with the laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work related injuries or illness without regard to fault.

**IV. Patient's Rights and Psychotherapist's Duties**

Patient's Rights:
-Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of the PHI. However, I am not required to agree to a restriction you request.
-Right to Receive Confidential Communications of the PHI by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communication of PHI by alternative means and at alternative locations.
-Right to Inspect and Copy – You have the right to inspect or obtain a copy of PHI in my mental health and billing records used to make decisions about you as long as the PHI is maintained in the record. The details of the access process will be discussed at your request.
-Right to an accounting – You generally have the right to receive an accounting of disclosures of PHI. The details of the accounting process will be discussed at your request.
-Right to a Paper copy – You have the right to receive a copy of the notice upon request even if you have agreed to receive the notice electronically.

Psychotherapist's Duties:
-To maintain the privacy of PHI and to provide a notice of my legal duties and privacy practice with respect to PHI.
-To reserve the right to change my privacy policies and practices described in this notice. Unless you are notified of such changes, it is required that I abide by the terms currently in effect.
-If I revise my policies and procedures, you will be notified in person or by mail.

**V. Complaints**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

**VI. Effective Date, Restrictions and Changes to Privacy Policy**

This notice is effective August 1, 2014. I reserve the right to change the terms of this notice and make the new notice provisions effective for all PHI that I maintain. In the event of such changes, I will provide you with a copy of the revised notice.

**Acknowledgement**

By law I am required to provide you with a copy of this notice and to obtain a signed acknowledgment from you that you have received it.

_____

I have read and understood the above information as shown by my signature below:

Name:_____
(please print)

_____ _____
Signature of Client Date

# GRH Consulting, LLC

## SERVICE AGREEMENT

Terms of Agreement:

I. Services: I provide psychological services, including but not limited to individual, marital and family therapy. I also provide, when appropriate, personal coaching services. These services are provided through the GRH Consulting practice. During the first scheduled session, any recommendations for treatment are first discussed with, and then ultimately approved by you, before treatment begins.

II. Sessions: The total number and frequency of scheduled sessions will be negotiated with you, depending on the treatment plan we develop and your personal needs. Each session is limited to 50 minutes in duration. If extra time is needed, it can be negotiated with me on an as needed basis.

III. Professional Fees: My session fee will be negotiated with you individually before or during our first scheduled session. I accept cash, check, Visa, Mastercard, Discover and American Express (Karen only). In addition to fees for regularly scheduled sessions, I will charge a fee for other professional services, including report writing, telephone consultations, attendance at meetings, or preparation of records or treatment summaries, as needed. Payment of fees, in full, is expected at the time of service. Any unpaid bills may be turned over to a collection agency after an appropriate attempt to collect. You are responsible for contacting your insurance company and understanding any insurance reimbursement you may be eligible for.

Prompt payment is appreciated and is independent of any insurance reimbursement you may receive.

IV. Appointment Cancellation Policy: You will be expected to give a minimum of 24 hours notice to cancel or change an appointment. If a session is missed and was not cancelled within 24 hours, I will charge my full-billed fee for the missed session. Extenuating circumstances are considered to this policy when appropriate.

V. Contact Information: Before or during our first session, I will supply you with my primary business phone number, email and website address; as well as instruct you on how to contact me after hours on an emergency basis.

VI. Confidentiality: All information concerning clients is held confidential and is released only through procedures consistent with the law and professional ethics. The limits of confidentiality are such, however, that clients who use their

mental health or emotional condition as an issue in a court of law may lose their right to confidentiality, and the court may successfully order records released and or staff to testify. The law also requires that if knowledge is gained that a person may harm him/herself or any other person, the requirement to help or warn takes precedence over issues of confidentiality. The law specifically obligates the therapist to report any reasonable suspicion of child or elder abuse. If there is ever a need to share confidential information about you or your treatment, I will first consult with you before the release of any information to outside individuals or organizations, and have you sign a separate release of information form. This policy may be superseded by state or federal law, as described above.

VII. Consent to Terms of Agreement: Your signature below indicates that you have read the information in this document, and agree to abide by its terms during our professional relationship.

A signature is required from the parent(s) or guardian(s) who have legal responsibility for the medical decisions for children in treatment. Each child, age 12 to 17, who is involved in treatment must also sign this agreement.

Client: _____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Witness: _____ Date: _____

# GRH Consulting, LLC

## CLIENT INFORMATION

Name:_____

Address:_____ Date of Birth:_____ Age:____

City:_____ Zip Code:_____

Referred by:_____

Phone Numbers: (Please indicate where you prefer to be called):

Home:_____

Cell:_____

Cell:_____

Work:_____

Text Messages okay?_____

Email Address:_____

**Emergency Contact**

Name:_____ Relationship:_____

Phone Numbers:_____

_____

If under 18, Legal Guardian's Name:_____

Address & Phone (if different):_____

## CONSENT FOR TREATMENT

**Informed Consent:** We ask that patients sign the following general consent to treatment. The patient may at any time decline specific recommendations.

I give my consent for services with *GRH consulting, LLC* and associated professional staff to include evaluation, psychotherapy, testing (if indicated) and involvement in the treatment planning process.

Signed:_____ Date:_____

Witness:_____ Date:_____