INTEGRATIVE PSYCHOTHERAPY
Elena Georgouses

NOTICE OF PRIVACY PRACTICES
January 2018

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.

Elena Georgouses, LCSW, acts to maintain the privacy of protected health information and provide individuals with notice of the practice's legal duties and privacy practices regarding protected health information as described in this Notice. My computers have passwords to protect our database, only the minimum necessary information is disclosed, and access of your medical information to anyone who works for me is limited to the essentials needed to perform their duties.

Provision of Notice: The practice will provide its Notice of Privacy Practices to every patient with whom it has a direct treatment relationship no later than the date of the first treatment to the client and it will be available in my office. This Notice is available via mail to any member of the public to enable prospective patients to evaluate the practice's privacy practices when making his or her decision regarding seeking treatment from the practice.

Documentation of Provision of Notice: When a client receives the Notice from the practice, the practice will request they sign their "Receipt of Notice of Privacy Practices" form. The form is filed with the patient's medical record. Should the client refuse to sign the form, it will be noted in the record that the client was given the Notice and refused to sign the form.

Effective Date and Changes to Notice: This Notice is effective January 1, 2018. The practice reserves the right to revise this notice whenever there is a material change to the uses or disclosures, the individual's rights, the covered entity's legal duties, or others privacy practices stated in the Notice. If the Notice is revised, it will be available upon request beginning on the revision's effective date. The revised Notice will be posted in the practice's reception area and made available to all patients, including those who had previously received their Notice. The patient will then be asked to acknowledge receipt of the updated Notice.

Complaints: If you believe your privacy rights are being violated, you may file a written complaint, describing the acts or omissions within 180 days of becoming aware of the violation. These letters should be addressed to Elena Georgouses, LCSW. PO Box 293 Vail, CO 81658.the practice will investigate each complaint. The client also has the right to contact,

Secretary
U.S. Department of Health & Human Services,
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201

The practice will not take any adverse action against any client who files a complaint against the practice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

My office is permitted by federal law to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing services to you. It may include documenting your symptoms, diagnoses, treatment and recommendations for future care or treatment. It also includes billing documents for those services.

An example of how we use your medical information for treatment is that as a courtesy, I might phone you to confirm an appointments. It is used for payment, when you may submit a bill to your insurance company, or provide information to your managed care plan reviewer.

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are the physical property of this office. The information in it belongs to you. You have the following rights:

- Request a restriction on certain disclosures of your health information (these requests may not always be granted, but will be carefully reviewed).
- Request a paper copy of the current Notice of Privacy Practices for Protected Health Information
- Request to inspect and copy your health record and billing record
- Appeal a denial of access to your protected health information, except in certain circumstances
- Request that your health care record be amended to correct incomplete or incorrect information. This request may be denied if the information was not created by us, was not part of the health information kept by the office, or is accurate and complete. However, if denied, you will be informed of the reason for the denial, and can submit a statement of disagreement to be kept with your record.
- Request that a communication of your health information be made by alternative means or at an alternative location
- Obtain an accounting of disclosures of health information (not including disclosures made at your request or authorization, or for treatment, payment, or operations)
- Revoke authorizations that you made previously to disclose information by writing my office, except to the extent that information or action had already been taken.

If you wish to exercise any of these rights, please contact Elena Georgouses.

Responsibilities of the Therapist

My office is required to maintain the privacy of your health information as required by law. This is why I am providing you with a Notice of duties and privacy practices regarding the information I collected and maintained about you. I will notify you if I cannot accommodate a requested restriction or request, and accommodate your reasonable requests regarding communicating health information.

Uses and Disclosures Not Requiring Authorization

As required by law, disclosure of abuse of a minor, disabled person, or of someone over age 60 is mandatory. Also, a client's relative, emergency room personnel, law enforcement or paramedical personnel may have to be contacted and given information in the event of an emergency (i.e. a threat to health or safety). I may disclose to the Food and Drug Administration (FDA) heath information related to adverse events related to medications, nutritional supplements, or other products.

Disclosure Requiring Authorization

In Colorado, specific written authorization is required to disclose or release information regarding mental health treatment (except in an emergency), alcoholism or drug abuse treatment, or AIDS (Acquired Immune Deficiency Syndrome). The federal HIPAA laws allow disclosure of necessary information required for purposes of treatment, payment, and health care operations.

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Acknowledgement of receipt/Signature

I acknowledge receipt of the Notice of Privacy Practices. The Notice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the therapist has reserved a right to change his or her privacy practices that are described in the Notice. I understand that a copy of any Revised Notice will be provided to me or made available upon written request.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the therapist. I also understand that I will not be able to revoke this consent in cases where the therapist has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the therapist's office.

_____ _____

Signature Date

If you are not the client, please specify your relationship to client

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Fee Agreement and Office Policy

The information, guidelines, and policies set forth herein are offered so that the client will have a full understanding of office procedures, billing policy and patient payment policy. This will also set forth the fee agreement. Current rates for professional services are as follows:

OUTPATIENT PSYCHOTHERAPY AND CONSULTATIONS $120.00 per 1 hour session
(Individual, couple or family, includes phone and internet)

Elena Georgouses' billing cycle is from the 1st through the end of each month. All clients will be sent an account statement itemizing those charges incurred during the billing cycle, plus any accumulated charges from previous month(s).

1. Clients are expected to pay for services at the time of the visit. It is considered the client's responsibility to provide all necessary billing information. The client acknowledges and agrees that it is his/her sole responsibility to pay for services rendered. Elena Georgouses doesn't do insurance billing, and therefore it is up to the client to submit their own claims.

2. Clients will be charged at regular therapy rates for appointments not canceled, or canceled less than 24 hours before the scheduled appointment.

3. Monthly statements not paid in full when due will draw interest at the rate of eighteen percent (18%) ANNUAL PERCENTAGE RATE on the unpaid balance, which translates into a periodic INTEREST or FINANCE charge of one and one half percent (1.5%) per month. A ten dollar ($10.00) rebilling fee will be added, at the sole discretion of the provider, to each account showing accumulated charges from the previous month. In addition, if it is necessary to initiate legal proceedings, consultation or advice to secure payment of the patient's incurred charges, the patient agrees to pay the provider's reasonable collection / attorneys' fees and costs associated therein.

4. Client acknowledges that psychotherapy is not an exact science. Client acknowledges that no guarantees or assurances have been made to him/her, nor will any be made. Client further acknowledges that his/her obligation to pay the provider's charges is not related to the success of the treatment accorded to the patient by the therapist.

5. Joint Custody: If both parents of a minor share fiscal responsibility, then both parents must sign the Agreement for Services form, and must provide their portion of the session fee at the time of service. In addition, both parents must give their written consent for the treatment/assessment of their child.

Until a signed copy of this form is placed on file, the patient is responsible for payment in full regardless of insurance coverage on the account. The patient's signature below evidences his (her) approval of all terms, conditions, and policies outlined above.

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Client Signature and Date