

Nicole Kramer, L.C.S.W.
7376 NW 5th Street
Plantation, Florida 33317
Florida License # SW-9086

CLIENT SERVICE CONTRACT AND NOTICE OF PRIVACY PRACTICES

Client Name: _____ **Social Security Number:** _____

This document describes some details about your professional relationship with me, Nicole Kramer, LCSW. It also describes how health information about you may be used and disclosed and how you can get access to this information. Please review it thoroughly and carefully. As you read each section, please ask me about anything you do not understand. Once you feel as though all of your questions have been answered to your satisfaction, kindly sign your initials on the designated line after each section to indicate that you have reviewed the section in its entirety and agree to it. You have the right to review this entire document before signing anything. The terms of this contract may change and if so, you may obtain a revised copy by contacting me. Upon completion of your review of the entire document and after all of your questions have been answered; please sign your full name in the designated area on the last page. Once again, I would like to thank you for engaging me to assist you. I look forward to working with you.

Authorization for Treatment:

Your signature indicates that you, either the client or a parent of a minor (guardian of) _____ hereby authorizes me to administer professional outpatient counseling, including all diagnostic and therapeutic treatments that may be considered advisable or necessary in my judgment. No guarantee or assurance is made as to the results that may be obtained.

Client Initials _____

Appointments and Fees:

Fees for services are payable at the time of each visit. There is a \$25.00 bank charge for any returned checks. Your appointment time is reserved just for you. Unless you object, I may contact you to provide you with appointment reminders or to notify you of scheduling changes at the phone numbers that you provide to me. You will be charged the full fee of your time slot if you do not provide me with 24 hour notice for cancellations. If you miss two (2) consecutive sessions without prior notification to my office and you do not reschedule, you will be administratively discharged and our relationship will then be terminated. You will receive, via U.S. mail, correspondence documenting said discharge and a list of referrals which I recommend you contact..

Client Initials _____

Emergency Medical Services:

I do NOT provide emergency medical and/or psychological care and therefore, should the need for such treatment and/ or become necessary, you must call 9-1-1. More specifically, if you, at some point in your outpatient counseling, start to feel as though you might hurt yourself or take your own life, you hereby agree that you will call 9-1-1 to report your status prior to ever calling me. Florida law does not impose a legal duty on a psychotherapist for the suicide of a client who is being treated in an outpatient situation.

During the course of your counseling, the need for emergency treatment and/or transfer to a hospital may become necessary and appropriate. I do not provide emergency medical and/or psychological care and therefore, should the need for such treatment and/ or transfer be deemed necessary and appropriate, I will call 9-1-1. Your signature on this document indicates your consent to such emergency treatment and/or transfer to a hospital and indemnifies me from any loss resulting from such emergency treatment and/or transfer. Your signature also indicates that you agree to assume sole responsibility for any and all charges incurred for such treatment.

Client Initials _____

Confidentiality:

I make every reasonable effort to safeguard the personal information, which you may share with me. This Notice of Privacy Practices provides information about how I may use and disclose protected health information about you. I provide a copy of this form to you to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In accordance with Florida law, any communication between you and I is "confidential" if it is not intended to be disclosed to third persons other than those persons present to further your interest in the consultation, examination, or interview, those persons necessary for the transmission of the communication, and those persons who are participating in your diagnosis and treatment under my direction.

Under Federal law, Protected Health Information (PHI) is the information I create and obtain in providing my services to you. Such information may include documenting your symptoms, examination, test results, diagnosis, treatment, and applying to your insurance plan for future care or treatment. It also includes billing documents for those services.

You have a privilege to refuse to disclose, and to prevent any other person from disclosing, confidential communications or records made for the purpose of diagnosis or treatment of your mental or emotional condition, including alcoholism and other drug Addiction, between you and I, or persons who are participating in the diagnosis or Treatment under my direction. This privilege includes any diagnosis made, and advice given, by me in the course of our relationship.

There are, however, several important instances when the privilege between you and I may be waived and confidential information may be released to others. Those instances are as follows:

(1) When I am a party defendant to a civil, criminal, or disciplinary action arising from a Complaint filed by you, in which case the waiver shall be limited to that action;

(2) When there is a clear and immediate probability of physical harm to you, to other individuals, or to society and I communicate the information only to the potential victim, appropriate family member, law enforcement or other appropriate authorities;

(3) When you agree to the waiver, in writing, or, when more than one person in your family is receiving therapy, when each family member agrees to the waiver, in writing. If you consent, I am permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and, health care operations. Appropriate written authorization will be obtained from you before we release your PHI for purposes of treatment, payment, and, health care operations.

Examples of uses of your health information for treatment purposes are:

- I obtain treatment information about you , and record it in a health record to be used by me;
- During the course of treatment, I determine that you will need to consult with another specialist such as your primary care physician, a psychiatrist, or another professional. With your permission, I will share the information with such specialist and obtain their input

Examples of use of your health information for payment purposes are:

- I submit for a request for payment to your health insurance company. The health insurance company requests information from me regarding services rendered. I will provide that information to your insurance company about you and the care you receive so the health insurance company can process your claim.
- I verify insurance coverage prior to your first appointment and obtain prior authorization and pre-certification when required to do so by your policy coverage.

Example of use of your health information for health care options:

- I may have Business Associates such as billing services, bookkeepers, etc. who may have access to your PHI when they are preparing our routine financial statements or entering payments from insurance companies.

Additionally, there are several important instances when there is no privilege (which means No confidentiality of communications) between you and I. Those instances are as follows:

- (1) For communications relevant to an issue in proceedings to compel hospitalization of you for mental illness, if I, in the course of diagnosis or treatment, have reasonable cause to believe you are in need of hospitalization;
- (2) For communications made in the course of a court-ordered examination of your mental or emotional condition.
- (3) For communications relevant to an issue of your mental or emotional condition in
In any proceeding in which you rely upon the condition as an element of your claim or defense or, after your death, in any proceeding in which any party relies upon the condition as an element of the party's claim or defense.
- (4) For any communication involving the perpetrator in any situation involving
Known or suspected child abuse, abandonment, or neglect, regardless of the
Source of the information requiring the report...
- (5) For any situation involving known or suspected abuse, neglect, or exploitation of a vulnerable adult (i.e., elderly person);
- (6) For preventing or controlling disease, injury, or disability, as required by law, I may disclose your PHI to the public health or legal authorities.
- (7) For health oversight activities, Federal law allows me to release your protected health information to appropriate health oversight agencies:
- (8) For specialized government functions, as authorized by law, such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.
- (9) For assistance in disaster relief efforts, as authorized by law;
- (10) For allowing funeral directors or coroners to carry out their duties, as authorized by law. .

Client Initials _____

By signing this form, you indicate the following:

- (1) That you consent to my use and disclosure of protected health information about You for treatment, payment, and healthcare operations.

- (2) That you have the right to revoke this consent, and may in fact do so by submitting a Written signed request from you to me;
- (3) That this is my Notice of Privacy Practices and that you have had the opportunity to Review this Notice of Privacy Practice;
- (4) That I reserve the right to change the Notice of Privacy Policies at any time;
- (5) That you have the right to restrict the uses of your information but that I do not have To agree to those restrictions;
- (6) That you may revoke this consent in writing at any time and all future disclosures will Then cease, however such a revocation shall not affect any disclosures we have Already made in reliance on your prior consent;
- (7) That you may condition treatment upon the execution of this consent. .

Client Initials _____

Signature on File:

Please accept a photocopy of this authorization as if it were an original executed authorization. You are hereby authorizing the release of any and all medical /treatment and payment information necessary to process your claims for a period of one (1) year from the date of execution of this contract. Your signature indicates that you place no limitations on history of illness or diagnostic/ therapeutic information including any and all treatment for substance abuse, psychiatric disorders, and acquired immune deficiency syndrome.

Client Initials _____

Assignment of Benefits:

Your signature indicates that you hereby authorize payment directly to Nicole Kramer, LCSW of the insurance benefits otherwise payable to you for the professional services. You also understand that you are financially responsible to me for all charges not covered by your insurance company, including but not limited to deductions, co-insurance, or disallowance of payments..

Client Initials _____

You're Health Information Rights:

The health record and billing records we maintain are the physical property of this office. The information in it, however, belongs to you. You have a right to:

- (1) Obtain an additional paper copy of this Notice of Privacy Practices for PHI by making a request at my office;
- (2) Request that you be allowed to inspect and receive a copy of your health record and billing record by delivering the request in writing to my office;
- (3) Appeal a denial of access to your PHI except in certain circumstances;
- (4) Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- (5) File a statement of disagreement if your amendment is denied, and require that the request for amendment and denial be attached in all future disclosures of your PHI;
- (6) Obtain an accounting of disclosures of your PHI as required to be maintained by law by delivering a written request to our office using. The accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request;
- (7) Request that communication of your PHI be made by alternative means or at an alternative location by delivering the request in writing to our office;
- (8) Revoke any authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

You have the right to review this document before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and healthcare operations purposes. If you want to exercise any of the above rights, please contact me during normal business hours and I will provide you with assistance on the steps to take to exercise your rights..

Client Initials _____

My Responsibilities:

I am required to:

- (1) Maintain the privacy of your PHI as required by law;
- (2) Provide you with a notice as to our duties and privacy practices as to the information We collect and maintain about you;
- (3) Abide by the terms of this contract;
- (4) notify you, if I cannot accommodate a requested restriction or request;
- (5) Accommodate your reasonable requests regarding methods to communicate health Information to you.

Reservation of Rights:

I reserve the right to amend, change, or eliminate provisions in my privacy practices and access practices and to enact new provisions regarding the PHI I maintain. If my information practices change, I will amend my Notice to reflect these changes. You are entitled to receive a revised copy of the Notice by calling or requesting a copy of my Notice or by visiting the office to obtain a copy..

Client Initials _____

To Request Information or File a Complaint:

If you have questions, would like additional information, or want to report a problem about the handling of your information, you may contact me, Nicole Kramer, LCSW at 954-648-7601.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at the office by delivering the written complaint to: Nicole Kramer, at 7376 NW 5th Street, Plantation, FL 33317.

You may also file a complaint by mailing or e-mailing it to the U.S. Secretary of Health and Human Services. I cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services as a condition of receiving treatment from my office. I cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Client Initials _____

By signing below, you acknowledge that you have received a copy of the Client Service Contract and Notice of Privacy Practices and that you have read and fully understand all the terms and conditions contained herein. Further, by signing below you are indicating your agreement to all of the terms and conditions contained herein.

Signature: _____

Printed Name: _____

Date: _____

Signature of Personal Representative of Client:

Date: _____

Description of Representatives Authority to Act on behalf of Client: (Example, parent, guardian, etc.)
