Jane Phillips, PHD, LCSW
& Associates, PLLC

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DATE OF FIRST APPOINTMENT

PARENT NAME: _____

Address: _____

City: _____ State_____ Zip code _____

Telephone _____ Email Address _____

COURT RELATED INFORMATION

PARENT NAME: _____

Address: _____

City: _____ State_____ Zip code _____

Telephone _____ Email Address _____

CHILDREN'S INFORMATION

Name:_____ Date of birth_____ School_____ Grade_____

Name:_____ Date of birth_____ School_____ Grade_____

Name:_____ Date of birth_____ School_____ Grade_____

Name:_____ Date of birth_____ School_____ Grade_____

Name:_____ Date of birth_____ School_____ Grade_____

Name:_____ Date of birth_____ School_____ Grade_____

EMERGENCY CONTACT:_____ Phone _____

TREATMENT AGREEMENT FOR REUNIFICATION THERAPY

IN THE INTEREST OF: _____

Cause #: _____

Welcome to the offices of Dr. Jane Phillips and Associates. This document contains important information about Dr. Phillips' professional services and business policies. Please read it carefully and let Dr. Phillips know if you have any questions. This document sets forth the terms of the engagement between you (the patient) and Jane Phillips, PhD, LCSW & Associates, PLLC (Dr. Phillips). When you sign this document, it will represent an agreement between you and Dr. Phillips. Please read this Agreement carefully and ask questions before signing it. If you decide that you do not wish to consent to these services and/or policies and would not like to proceed with services provided by Dr. Phillips, there will be no charge for future appointments or services cancelled as a result.

SCOPE OF REUNIFICATION THERAPY SERVICES

You are engaging Dr. Phillips to provide you with Reunification Therapy. No other services will be provided.

Dr. Phillips does not prescribe or provide recommendations for prescription drugs. If you have any questions regarding your medications, please consult your prescribing healthcare provider. Dr. Phillips does not provide legal advice, she will not provide a custody evaluation or make recommendations regarding access to or visitation time with your minor children.

It is agreed that the objective of Reunification Therapy is not to determine if it is in the child(ren)'s best interest to have contact with one or the other of the parents. Rather, the Court, the attorneys and the parents understand that it IS in the child(ren)'s best interest to have meaningful relationships with both parents, who have shown the ability to act in the best interest of the child(ren). The intervention is intended to help the child(ren) have a meaningful relationship with both parents. By your signature at the end of this document, you agree that:

A. Dr. Phillips has been appointed by the court for the purpose of providing court-ordered Reunification Therapy. A copy of your court order must be received prior to beginning services.
B. Dr. Phillips's role is to assist with Reunification Therapy and she will not serve as a custody evaluator, arbitrator or consultant for litigation.
C. Under judicial appointment, Dr. Phillips is protected with immunity from civil litigation, pursuant to Bird v. W.C.W. 8668 S.W.2d 767 (Tex. 1994).
D. Dr. Phillips does not work for either party regardless of their responsibilities for paying the fees for therapy.
E. Reunification Therapy will continue until Dr. Phillips makesthe recommendation that Reunification Therapy is complete. In the event that either or both parents wish to terminate the therapy, he/she will provide notice to Dr. Phillips and the other parent in writing.

Dr. Phillips conceptualizes psychotherapy from a systems perspective, in which the experiences of an individual are interrelated, both influencing and being influenced by the behaviors of the other member(s) of the individual's relationship or family. Within this general framework, Dr. Phillips chooses theoretical approaches suited to the

particular presenting issues and concerns of the patient. Dr. Phillips views Reunification Therapy as a collaborative task, in which you take an active role in working toward the established goals, both within and between sessions.

Psychotherapy is intended to help you reach a better understanding of specific problems and/or increased self-awareness. It is also intended to work toward improvement of the identified problem, offer support in problem solving, provide some symptom relief and improvement in coping with activities of daily life. The duration of therapy depends on how quickly your therapeutic goals are achieved. Your progress in psychotherapy and its outcome depends upon many factors including, but not limited to, your level of motivation and desire to change, the effort that you put forth in following through with agreed upon therapeutic tasks outside of sessions, keeping your appointments, and your willingness to be open with Dr. Phillips as you work together.

Therapy may have both risks and benefits. It often involves discussing difficult or unpleasant aspects of your life, and you may experience uncomfortable feelings about these discussions, such as sadness, guilt, anger and frustration. Some of the changes you make as a result of psychotherapy may not be welcomed by other people in your life. This may result in some strain in your relationships with family and others. Therapy may disrupt a romantic relationship. Sometimes, too, it is possible for a patient's problems to worsen immediately after beginning therapy. Most of these risks are to be expected when people are making important changes in their lives.

On the other hand, research has shown that therapy may also be beneficial, leading to improvements in individual psychological health, communication and problem-solving skills, and relationship satisfaction. While Dr. Phillips will exert her best professional efforts in counseling and assessment, no guarantee or representation has been made or can be made as to the outcome of the matters referred to her or of a specific date of completion.

DESCRIPTION OF ROLES AND RELATIONSHIPS

Dr. Phillips cannot have a prior personal, professional or business relationship with either party, step-parent, or child(ren) in this case. If, during the initial assessment, it becomes apparent that such a relationship exists, the process will be stopped and Dr. Phillips will notify the Court that she must withdraw from the case so that another therapist can be assigned. If you believe that there are any such relationships, please make this known to Dr. Phillips as soon as possible.

Dr. Phillips's role is to remain impartial throughout the Reunification Therapy process. In order to protect her impartiality, the following procedures will apply:

- Dr. Phillips will not have any ex-parte communications regarding the specifics of your case with either attorney during the Reunification process. If resolution of a particular issue becomes necessary, Dr. Phillips will schedule a telephone conference call with both attorneys present.
- Dr. Phillips may contact either attorney to request information.
- Following the termination or completion of Reunification Therapy, Dr. Phillips cannot fulfill a different role with either party, such as serving as a therapist or mediator.

INITIAL ASSESSMENT

Your first session and possibly the first few sessions will involve an assessment of the therapy needs and goals for each party and child(ren).

GOALS OF REUNIFICATION THERAPY

The goals for Reunification Therapy may include:

- Fostering healthy child adjustment
- Facilitating the implementation of the previously agreed or ordered parentingtime
- Facilitating adequate parent functioning and roles
- Restoring or facilitating contact between_____and his/her children:
  Names of children:

  _____ _____

  _____ _____
- Working with each parent and their child(ren) towards the goal of identifying and separating each child's needs and views from each parent's needs and views
- Assisting the parents in fully understanding the needs of each child and the negative repercussions from the child(ren) of a severed or compromised relationship with a parent in their young lives and as adults.
- Working with each family member in assisting them to form more appropriate parent-parent and parent-child roles and boundaries
- Addressing possible distortions of the child(ren) and replacing these with more realistic perceptions that reflect the child's actual experience with both parents
- Assisting the child(ren) in differentiating self from others and exercising age-appropriate autonomy
- Helping each parent differentiate valid concerns from overly negative, critical and generalized views relating to the other parent
- Assisting the parents in resolving relevant parent-child conflicts
- Assisting in improving each parent's parenting skills and family communications skills

THE REUNIFICATION PROCESS

A. While_____and_____may have different views about the cause and reasons for the child(ren)'s reluctance or refusal to have contactwith _____ _____, they understand the objectives defined above and that they each need to be a part ofthe solution to meet those objectives.

B. _____and_____have agreed to the involvement of the entire family, in various combinations, as directed by Dr. Phillips. The process will include meetings between Dr. Phillips and each of the parents and the child(ren) individually and jointly. The process may include interviews or meeting with other family members as deemed necessary by Dr.Phillips.

C. Dr. Phillips will be assisting to implement the previously agreed to Court Ordered parenting plan.

D. Dr. Phillips may provide a report to the Court if asked to do so.

E. Both parents will provide all documentation, information and releases requested by Dr. Phillips.

F. Dr. Phillips will be at liberty to contact any third parties, with proper releases, she deems necessary in order to facilitate the Reunification Therapy.

G. Dr. Phillips may recommend adding additional professional support for the child(ren) or parents.

H. Dr. Phillips may choose to contact other professionals involved with the family to both give and receive information to better meet the objectives and goals of the intervention.

I. Parents and step-parents will support the Reunification Therapy intervention. This support includes respecting the child(ren)'s right not to discuss with the parents their sessions with Dr. Phillips. The parents _____ _____and_____will not ask their child(ren) for information about their session or parenting time with the other parent.

THERAPY SESSIONS AND ATTENDANCE

Each session will be of 50 minutes duration unless other arrangements have been made in advance. Dr. Phillips will make every effort to begin your sessions promptly. If you are late to an appointment, she cannot extend the session time without prior arrangement. If you carry a cell phone or any other device that will beep, buzz, or ring, please turn it off during the appointment so that your session is not disrupted.

There will be NO audio or visual recording of sessions. Unauthorized recording of any kind will be sufficient basis for Dr. Phillips to terminate treatment and provide the Court with a report regarding the termination of treatment.

If you provide 24 hours advance notice for an appointment cancellation, you may reschedule the appointment and you will not be charged the full session fee. Any missed appointments or appointments cancelled within 24 hours will result in you being charged the full session fee of $225. Fees for late cancellations/missed appointments must be paid in full prior to additional services being provided and are not covered by most insurance plans.

TREATMENT PLAN

Following the initial assessment, the parties, the child(ren) and Dr. Phillips will discuss and agree on specific goals for the Reunification Therapy, and Dr. Phillips will prepare a written treatment plan. Goals will likely change as therapy progresses and should be renegotiated as needed. The therapeutic approach used will vary and should be discussed with Dr. Phillips whenever you have questions or when you believe therapy is not helpful.

Minors. A parent who signs this agreement and gives their informed consent for his or her minor child(ren) to receive services from Dr. Phillips acknowledges that he or she has the legal conservatorship and authority to consent to the evaluation and treatment of the child(ren). By the signature below, the parent further agrees to provide a copy of the Divorce Decree or Court Order that confirms the parent's legal authority to consent to the child(ren)'s evaluation or treatment to Dr. Phillips at the first appointment or as soon as practicable.

TERMINATION OF TREATMENT

When you and Dr. Phillips agree that you have met your treatment goals, she will review your progress and provide a final report to the Court. However, there are a few instances in which the therapeutic relationship may terminate before reaching that point. This agreement may be terminated for any of the following reasons:

1. Refusal of one or both parties to participate in Reunification Therapy;

2. Failure of one or both parties to pay or perform according to the terms of this Agreement;

3. Indictment or filing of criminal charges against a party.

In addition, if Dr. Phillips believes that her approach and training is no longer appropriate for your specific concerns, or that you are not benefitting from treatment, she will inform you and the Court that she can no longer provide services and will give you referrals to other mental health professionals who may be better suited to meet your needs.

Dr. Phillips's decision regarding the termination of Reunification Therapy will be final. If you request and authorize it in writing, Dr. Phillips will confer with your new therapist to help with the transition. Upon termination of therapy for any reason, the termination will be confirmed in writing.

PROFESSIONAL FEES
Dr. Phillips's hourly fee for providing Reunification Therapy is $225. Sessions lasting over one hour will be charged pro-rated fees for the additional time. Fees may change with 30 days notice. The Court may order that the costs of Reunification Therapy be paid by one or both parties, and the Court may reallocate the division of the costs. The parties agree to keep Dr. Phillips apprised of any Court Order that affects payment for the costs of Reunification Therapy. The court's orders for the division of costs supersedes this document.

Dr. Phillips accepts cash, checks or credit card for payment of Reunification Therapy; she does not accept post-dated checks or barter. Checks should be made payable to Jane Phillips, PhD, LCSW. Rates are subject to change at the sole discretion of Dr. Phillips, with notification provided in advance of your next session. All fees must be paid at the beginning of each appointment. In addition to therapy appointments, Dr. Phillips may charge a $250 hourly fee for other professional services that may be necessary related to court-involved therapy. She will prorate the hourly fee for the additional services based on 15-minute increments rounded up to the nearest 15 minutes. Other services may include email correspondence, report writing, telephone conversations, consultations, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, attending hearings and/or depositions or responding to subpoenas (as set forth below in the section on Litigation Policies and fees for court- related services), and the time spent performing any other service that you may request of Dr. Phillips.

Checks returned for non-sufficient funds are subject to a service fee of $35. Past due amounts will accrue interest at 10% per month. If you do not make regular payments on past due amounts, your account may be sent to collections.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, Dr. Phillips has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, the costs will be included in the claim.

LITIGATION POLICY AND FEES FOR COURT-RELATED SERVICES
It is agreed should your attorneys or anyone acting on your behalf subpoena records from Dr. Phillips's office, or subpoena Dr. Phillips to testify in court or in any legal proceeding, your signature at the end of this document will indicate your willingness to abide by this agreement.

Dr. Phillips's hourly fee for litigation-related services (including review and preparation for testimony, travel time to and from deposition or court, actual time waiting to testify and testifying in court or deposition, etc.) is $250. Reimbursement is also required for actual out-of-pocket travel expenses including mileage and/or transportation costs, tolls, meals and lodging. Charges will also be accumulated for time spent preparing, travel time, attorney consultations, parking fees and copies.

If Dr. Phillips is required to testify in court or give a deposition in Tarrant or Hood County, a retainer of $1,500 for a half-day appearance and $3,000 for a full-day appearance will be required in advance to hold the date. If Dr. Phillips is required to testify in court or give a deposition outside of Tarrant or Hood County, a retainer of $2,000 for a half-day appearance and $4,000 for a full-day appearance will be required in advance to hold the date. All payments are due at least one week prior to the scheduled court appearance or deposition, and all such fees shall be paid by the party who issues the subpoena or deposition notice.

When Dr. Phillips is requested to appear in court or give a deposition, she has to clear her clinical schedule and is unable to schedule patients, so there is a 72-business hour cancellation policy for all court appearances and depositions. For example, if the court appearance or deposition is scheduled for Monday, Dr. Phillips must be notified of any cancellation no later than 8:00 am on the Wednesday before. Any cancellations that occur within the 72-hour time frame of the court appearance or deposition are NONREFUNDABLE.

If Dr. Phillips is subpoenaed to provide records or testimony, you acknowledge and agree that the party who issues the subpoena or requires her to testify will pay for all of her professional time, including preparation and transportation charges.

CONTACTING DR. PHILLIPS
Dr. Phillips does not provide emergency services in Reunification Therapy. Other than session attendance, the only way Dr. Phillips may be contacted is by the office phone at (682) 225-6990. Dr. Phillips's office hours vary and she is often not immediately available by telephone.

Dr. Phillips and her administrative assistant routinely return calls within 24-48 hours during regular business hours, Monday through Thursday, 9:00 a.m. to 3:00 p.m. If you are difficult to reach, please inform her of the best time to reach you when leaving a message. Please set your phone to accept private calls, otherwise Dr. Phillips's office staff may be unable to reach you.

If you experience a life-threatening emergency, you should go immediately to the nearest hospital emergency room and request to see a mental health professional. Another option is to call 911. If you are suicidal you can call the Suicide and Crisis Center of North Texas Hotline at (214) 828-1000. If you have insurance, call the number listed on the back of your card and get a referral to an in-network psychiatric hospital for consultation with an intake specialist.

USE OF ELECTRONIC COMMUNICATIONS

Dr. Phillips will not accept or respond to emails from patients except for scheduling purposes. Any e-mail you send to Dr. Phillips's office will be printed and will become part of your clinical record.

Dr. Phillips does not exchange text messages with patients. If a text is sent to Dr. Phillips's telephone number, it will be deleted without being read. All clients should contact Dr. Phillips's office by telephone for any substantive matter relating to their therapy.

Dr. Phillips does not engage in communication or relationships via social media with patients. This is for the protection of your privacy as well as the therapy relationship. If you happen to encounter Dr. Phillips through social media or the internet, please feel free to discuss this with her in session. The therapy relationship is of a professional nature rather than social. Dr. Phillips does not respond to messages or accept "friend" requests from current or former clients on social networking sites due to the fact that these sites can compromise clients' confidentiality and privacy.

Dr. Phillips would never post information about a client on a public website. We ask that you respect Dr. Phillips's privacy and refrain from posting any "reviews" or other information regarding her or her practice on any website such as HealthGrades, Angie's List, or other forum for posting public reviews of health care providers. By your signature below, you agree that you will not post any "review" or any other information on any website without Dr. Phillips's prior written permission. If we believe that you have violated this agreement, we reserve the right to terminate our professional relationship immediately and refer you to other mental health professionals.

INTERACTIONS OUTSIDE THE OFFICE

If you and Dr. Phillips happen to encounter each other outside of the professional setting, she will not address you unless you speak to her first. This is also for the protection of your privacy from those persons who may be with you. Dr. Phillips happily returns a friendly greeting but will allow you to take the initiative if you would prefer to do so.

PROFESSIONAL RECORDS

Documentation of sessions consists of a summary of each meeting and may include general issues addressed, possible symptom presentation or change, level of functioning, mental status, diagnosis and treatment plans. Texas law requires Dr. Phillips to maintain appropriate treatment records for 5 years from the last date of service. If the patient is a minor child, Dr. Phillips must maintain treatment records for 5 years or 5 years from the date the child turns 18.

Texas law requires that all requests to review or obtain copies of your records must be made in writing. Dr. Phillips requires that patients sign an appropriate authorization before she releases any records to them. The records of Reunification Therapy may contain information regarding each party, step-parents (if any), the child(ren), and possible others who are not part of the Reunification Therapy process. Generally, Dr. Phillips would be required to redact confidential information about third persons who have not consented to the release of their confidential information. However, because the records of Reunification Therapy are not confidential, upon receipt of a written request by either party, Dr. Phillips will provide a copy of the records to the attorneys for both parties upon receipt of a signed Authorization and payment of the fee. By your signature below, you provide your express, written Authorization for the release of your records under such circumstances.

If you request a copy of your records, Dr. Phillips will provide them to you within 30 days of receiving the request, the signed Authorization and payment, unless Dr. Phillips believes that to do so would endanger your life or the life of another person. If Dr. Phillips believes that she must withhold the records due to a situation involving life

endangerment, she will write you a letter to explain her reasons for withholding the records and your options. A copy of that letter will be maintained in your file.

The HIPAA Privacy Rule provides that a fee for providing records must be reasonable and cost-based. Dr. Phillips has determined that a reasonable minimum, cost-based charge for providing you with a copy of your records will be $50.00. By law, we are not required to provide copies of requested records until the stated fee is paid.

LIMITS ON CONFIDENTIALITY

In general, the privacy of all communications between you and a therapist is protected by law, and Dr. Phillips can only release information about her work with you to others outside your relationship with your written permission. However, because Dr. Phillips is providing Reunification Therapy pursuant to a Court Order, the parties will not have the same expectation of privacy as they would for non-Court ordered therapy. There is no privileged communication between you and Dr. Phillips. Any information gained during Reunification Therapy may be communicated to the Court and to the attorneys involved in the case, including those who may become involved in the case at a future time. No information provided to Dr. Phillips by either party, or the child(ren) is confidential, and may be shared with the Court and attorneys.

Information about payments, including the amount of payment(s), the source(es) of payment(s) and the form of payment(s) is not confidential and may be shared with the parties, the attorneys and the Court.
Although Dr. Phillips may disclose information to the parties, the attorneys and the Court, she will generally not disclose information regarding the Reunification Therapy to other persons or entities who are not involved with the therapy. There are a few exceptions outlined below:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-client privilege law. If your records are subpoenaed or if a judge issues a court order for your records, Dr. Phillips is legally obligated to comply. In the case of a subpoena, Dr. Phillips will contact you so you (and/or your attorneys) can take steps to contest the subpoena. If you do nothing to contest the subpoena after being notified by our office, Dr. Phillips will obey the subpoena.

2. If Dr. Phillips believes that you are a danger to yourself or to other persons, she may contact medical or law enforcement personnel and disclose whatever confidential information is necessary to protect you or others.

3. If you disclose information that leads Dr. Phillips to suspect that a minor, elderly, or disabled person is being abused or neglected, she is required by law to notify authorities within 48 hours and she will comply with this requirement.

4. If you file a lawsuit or a complaint against Dr. Phillips for any reason related to your therapy, Dr. Phillips is allowed to use confidential information to defend herself.

5. If a court order or other legal proceeding or statute requires disclosure of your information, Dr. Phillips will obey the court order or the law.

6. If you waive the rights to privilege or give written authorization to disclose information, Dr. Phillips will comply with your authorization.

7. Information contained in communications via computers with limited security/control, such as e-mail and telephone conversations via cell phone is not secure and can compromise your privacy.

8. If Dr. Phillips learns of previous sexual exploitation by a mental health provider, she is required to report it to the district attorney in the county of the alleged exploitation and the appropriate licensing board of the provider. The client has the right to remain anonymous when the report is filed.

Dr. Phillips maintains commercially reasonable physical, electronic, and procedural safeguards that comply with professional standards to guard your non-public personal information. By your signature below, you acknowledge that you have been advised of these limits to confidentiality.

THIRD PARY PAYORS/INSURANCE

Full or partial payment for Reunification Therapy services is probably not covered by your employer, a government agency or your insurance company (collectively referred to as a “Third Party Payment Plan”). Please consult your insurance contract for the terms of your eligibility, your benefits and reimbursement procedures, as Dr. Phillips

cannot do this for you. Receipts for your appointment for you to file with your insurance company will be provided to you in a timely manner after each appointment.

If you would like receipts provided another way, please discuss this with Dr. Phillips. Please be advised that your insurance company may send payments to Dr. Phillips by mistake. If Dr. Phillips does receive payment from your insurance company for fees that you have already paid and you have no other outstanding charges to offset the payment, she will document the payment as appropriate and issue a check to you for the same amount as the payment received from the
insurance provider.

PLAN FOR PRACTICE IN CASE OF DEATH OR DISABILITY

In the event of Dr. Phillips's death, incapacity or disability, she has made arrangements for another therapist to take over her practice, meet with clients, make appropriate referrals to other providers, if necessary, and take all reasonable steps to manage the practice for the benefit of Dr. Phillips's clients. By your signature below, you authorize Dr. Phillips's designee to contact you directly, and use and disclose your confidential mental health information and records for the stated purposes.

ASSOCIATES

Dr. Phillips shares space to other professionals. None of the other professionals or contract providers are employees of Jane Phillips, PhD, LCSW and Associates. Only Dr. Phillips and her assistant are employees of Jane Phillips, PhD, LCSW and Associates. Any concerns about other professionals or a staff member should be directed to Dr. Phillips.

COMPLAINTS

You have a right to have your complaints heard and resolved in a timely manner. If Dr. Phillips cannot work things out to your satisfaction you may file a complaint with her licensing board: The Texas State Social Worker Examiners, (512) 719-3521. If you have a complaint concerning the HIPAA Privacy Regulations, you may contact the U. S. Department of Health and Human Services, Office for Civil Rights, at OCRMail@hhs.gov.

HIPAA Compliance Standards

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSEDAND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the NASW Code of Ethics and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities i you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at 682-225-6990.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record

set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at 682-225-6990 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013.

Please Initial

_____ I understand the nature of the proposed therapeutic treatment and I give my informed consent for Reunification Therapy by Jane Phillips, PhD, LCSW

_____ I understand that the current fee for service is $225 for established patients per 50 minute period scheduled, and fees may change with 30 days notice. I have also been informed regarding fees related to legal proceedings and Dr. Phillips's litigation policy and I agree to abide by it.

_____ I understand that the counseling session is 50 minutes in length unless other arrangements have been made for 90 minute or 120 minute sessions.

_____ I agree to pay the fees for which I am responsible and fulfill my obligation to participate in Reunification Therapy as ordered by the Court. I agree that Dr. Phillips may suspend scheduling of any sessions until the requested retainer is paid.

_____ I understand that the fee for missed appointments without 24-hour prior notification is $225 per hour. To avoid a fee, I will give 24 hours advanced notice if I must cancel or reschedule an appointment.

_____ I understand that if I am experiencing a medical or mental health emergency, I have been advised to dial 911 or go to nearest emergency room, and I agree to abide by these instructions.

_____I have read and understood the terms of this Agreement and I agree to comply with them. I was given the chance to ask questions of Dr. Phillips before signing the Agreement.

_____I agree that this Agreement will stay in effect until I revoke it in writing. I understand that any written revocation must be dated AFTER the date of this Agreement and must be provided to Jane Phillips, PhD, LCSW.

_____A copy of this Agreement has the same force and effect as an original.

By my signature below, I also acknowledge that I have received and read the HIPAA Notice of Privacy Practices. This Treatment Agreement for Reunification Therapy is intended to cover

_____[INSERT NAME OF PARENT] and _____

_____[INSERT NAMES OF SPECIFIC CHILDREN].

_____ _____

Signature of Client or Parent Date Signed

_____

Printed name of Client or Parent

Contact Agreement

We request the information below so that we are better enabled to protect your privacy and ensure the best possible service. Please initial the services for which you agree to use for the following contacts.

As a courtesy to our patients, we may confirm upcoming appointments by email or phone call approximately one to three days prior to the scheduled session.

_____I authorize Jane Phillips, PhD, LCSW & Associates to leave information regarding my appointments, treatment and/or account balance on the answering machine/voice mail at the following phone number: (please circle)
_____ Home / Work / Mobile

_____Furthermore, I authorize Jane Phillips, PhD, LCSW & Associates to speak tothe following people regarding confirmation of my appointments, treatment and/or accountbalance:
_____ Appt. / Treatment / Account
_____ Appt. / Treatment / Account

_____*Furthermore, I authorize Jane Phillips, PhD, LCSW & Associates to correspond withme via the following email account regarding my appointments, treatment and/or accountbalance:
_____

Email Address
* Required if you wish to receive a response to an email message from you.

_____

Signature of Client or Parent Date Signed

_____

Printed Name of Client or Parent