Client Information and Office Policy Statement

Welcome! Thank you for choosing the Hudson Valley Center for Cognitive Therapy (HVCCT). We understand that the decision to seek therapy is a very important one, and we are honored that you have decided to work with us. We would like to take this opportunity to acquaint you with information relevant to treatment, confidentiality, and office policies.

Cognitive Therapy: Cognitive Therapy is one of the most state-of-the-art and extensively researched methods of psychotherapy. A central idea in Cognitive Therapy is that by modifying your thinking, you can learn to change your mood and behavior. This method has helped thousands reduce emotional distress and develop more effective coping skills that can be used in everyday life. You will make the most gains by playing an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress. You will be asked to complete questionnaires and complete "homework" assignments. Your progress in therapy greatly depends on what you do between sessions.

Financial Terms: Payment is due every session. There will be a $25 charge for any returned checks. In addition to therapy appointments, your therapist will prorate the session fee for time spent for other professional services rendered. Other services may include but are not limited to report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, and preparation of records or treatment summaries. If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for his/her professional time, even if he/she is called to testify by another party. The fees for professional time related to legal involvement (e.g., preparation and attendance at a legal proceeding) differ from that of the therapy session fee and will be discussed at that time.

If you fail to meet your financial responsibilities within 60 days and arrangements for payment have not been agreed upon, we reserve the right to turn your account over to a collection agency or appropriate court. If such action is necessary, you will be responsible for any expenses incurred. Please call Dr. Christine Ziegler at (845) 353-3399 x12 if you have any questions regarding these matters.

Insurance Reimbursement: Please note that services provided by therapists working at the HVCCT office are out of network for your insurance plan. Most insurance plans offer an out of network benefit for mental health. Please check with your insurance carrier regarding the details of your plan. It is your responsibility to find out about your coverage (e.g., deductibles, number of covered sessions, authorization needed to begin therapy, etc.). At your request, your therapist will prepare a form that you can submit to your insurance for reimbursement as outlined by your plan.

Cancelled/Missed Appointments: A scheduled appointment means that time is reserved only for you. **If an appointment is missed or cancelled with less than 24 hours notice, you will be billed at your usual fee.**

Confidentiality: Issues discussed in therapy are generally confidential. However, there are limits to confidentiality. These situations include: 1) suspected abuse or neglect of a child, elderly person, or a disabled person, 2) when your therapist believes you are in danger of harming yourself or another person or you are unable to care for yourself or another person, 3) if you report that you intend to physically injure someone, the law requires your therapist to inform that person as well as legal authorities, 4) if your therapist is ordered by a court to release information, 5) when your insurance company is involved (e.g., filing a claim, insurance audits, case review, etc.), 6) in natural disasters whereby protected records may become exposed, or 7) when otherwise required by law. You may be asked to sign a Release of Information so your therapist may speak with family members or other professionals involved in your care.

Contacting Your Therapist: Your therapist may not be immediately available by telephone. When your therapist is unavailable, the telephone is answered by an answering machine which is monitored frequently. If it is a clinical emergency you are unable to reach your therapist, go to your nearest emergency room.

Electronic Communication/Email and Texting Policy: You are urged not to send text and email messages that contain clinical information since they are not HIPAA compliant and your privacy could be compromised. Your therapist and the HVCCT do not guarantee your privacy for any electronic communication and do not guarantee that your email or text will be read or responded to in a timely manner. If you need to speak to your therapist before your next scheduled appointment, you should contact him or her by telephone. If you do choose to send an electronic communication, you agree to assume full responsibility for the risks, and will not hold your therapist or the HVCCT liable for any possible breach in confidentiality or failure to respond in a timely manner.

Policy Regarding Animals: For health and safety reasons animals of any kind are not permitted in the building. This includes emotional support, therapy, or comfort animals. As per ADA regulations, the only exception is animals that have been certified to be service animals. HVCCT therapists also do not write prescription letters for those who are interested in utilizing emotional support animals.

Record Keeping: A clinical chart is maintained describing your condition, your treatment, and progress, as well as notes describing each therapy session.

Client Satisfaction: We at the HVCCT are committed to working with you to the best of our ability. We appreciate and welcome feedback about your therapy experience, particularly while you are in treatment. If you have any concerns at any point with the course of your treatment, please do not hesitate to speak candidly to your therapist. If your concerns persist, please call Dr. Christine Ziegler, Director of the HVCCT. It is very important to us that you are comfortable working with your therapist and that you feel that your treatment is going in the direction you wish.

Consent for Treatment: You authorize that your therapist may carry out or order psychological examinations, treatment, and/or diagnostic procedures that now or during the course of your care are advisable. You understand that the purpose of these procedures will be explained to you upon request and subject to your agreement. You also understand that while the course of therapy is designed to be helpful, it may, at times, be difficult and uncomfortable.

I UNDERSTAND AND AGREE WITH THE STATEMENTS ABOVE AND HEREBY SIGN:

______________________	____________	______________________	____________
Client Signature	Date	Therapist Signature	Date

Personal Data Form

Name: ____

Address: ____

Phone Numbers:	Okay to call?	Okay to leave message?
Home: ______________________	Yes / No	Yes / No
Work: ______________________	Yes / No	Yes / No
Cell: ______________________	Yes / No	Yes / No

Special Instructions for leaving messages (if any): ______________________________________

How were you referred to us? ____

Age: _____ Birth date: ______________

Gender: Male ____ Female ____

Relationship Status: (check applicable)
___ Single ___ Married ___ Divorced
___ Separated ___ Widowed ___ Domestic Partner

Student: Yes ____ No ____ Full Time ____ Part Time ____

Education: ____

Occupation: ______________________________ Full-Time ____ Part-Time ____

Primary Care Physician: ____

Emergency Contact: Name: ______________________ Relationship: __________________

Phone Number(s): ____

Please describe your reason(s) for seeking treatment at this time: _________________________

____

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At the end of therapy, do we have your permission for the Director, Dr. Ziegler, to contact you to ask you about your experience at the HVCCT? Yes _____ No _____

Medical History

Name: ____ Date: _____________________

1. Who is your physician or the physician who sees you most often? ____________________

2. When was the last time you had a physical check-up? ____________________

3. Have you been treated by a physician or hospitalized in the last year? Yes ___ No ___

   If yes please specify: ____

4. Has there been any change in your physical health in the past year? Yes ___ No ___

   If yes please specify: ____

5. Are you taking any medication (psychiatric, non-psychiatric, over the counter) at the present time?

   Yes ___ No ___ If yes, please list (continue on the back if needed):

   Medication Dosage/Frequency Name of Prescriber

   1.

   2.

   3.

   4.

   5.

6. Have you ever had a history of (circle all that apply):

High/ Low Blood Pressure	Diabetes	Anemia	Seizures/Epilepsy
Cardiac Problems	Asthma	Tuberculosis	Cancer (Type: _____________)
Thyroid Problems	Ulcers	Tics	Other: ____________________

7. Are you pregnant or think you may be pregnant? Yes ___ No ___ N/A ___

Psychiatric History

Name: ___________________________________ Date: _________________

1. Have you ever been hospitalized for any emotional or psychiatric reason? ___ Yes ___ No
   If yes, please complete information below:
   Dates Name of Hospital Reason for Hospitalization Was it Helpful?

2. Have you ever received psychiatric or psychological treatment before? ___ Yes ___ No
   If yes, please complete information below:
   Dates Name of Professional Reason for Treatment Was it Helpful?

3. Are you currently taking any medication for psychiatric reasons? ___ Yes ___ No
   If yes, please complete information below:
   Medication Dosage Frequency Name of Prescriber

4. Have you ever made a suicide attempt? ___ Yes ___ No If yes how many attempts? _________
   Approximate date What did you do to hurt yourself? Were you hospitalized?

5. Has anyone in your family ever made a suicide attempt? ___ Yes ___ No
   If yes, how is this person related to you? ____________________

6. Has any member of your family died from suicide? ___ Yes ___ No
   If yes, how is this person related to you? ____________________

7. Does anyone in your family have a history of mental health issues (e.g., depression, anxiety, drug abuse)?
   ___ Yes ___ No *If yes, please complete information below:*
   Family Member List psychiatric, drug, or alcohol problem

8. Has anyone is your family received psychiatric treatment? ___ Yes ___ No

9. Please list all psychiatric medications you have taken in the past. (Use back if necessary).

10. Have you ever experienced abuse as a child? ___ Yes ___ No ___ Not Sure
11. Have you ever experienced abuse as an adult? ___ Yes ___ No ___ Not Sure
12. Have you ever experienced sexual abuse as a child? ___ Yes ___ No ___ Not Sure
13. Have you ever experienced rape including date or marital rape? ___ Yes ___ No ___ Not Sure
14. Have you ever experienced verbal abuse as a child? ___ Yes ___ No ___ Not Sure
15. Have you ever experienced verbal abuse as an adult? ___ Yes ___ No ___ Not Sure

Alcohol and Drug Use History

Name: ____ Date: ______________________

1. When did you last drink alcohol? __________________________________
2. Has alcohol ever caused any problems for you? ___ Yes ___ No
3. Has anyone ever told you that alcohol has caused a problem for you or complained about your drinking? ___ Yes ___ No
4. Has your use of alcohol ever caused a relationship problem with anyone? ___ Yes ___ No
5. Has your use of alcohol ever caused any problems at work or performing other responsibilities? ___ Yes ___ No
6. Has your use of alcohol ever caused any legal problems such as being arrested or DUI? ___ Yes ___ No
7. Have you ever gotten "hooked" on prescribed medication or taken a lot more than you were supposed to? ___ Yes ___ No
   If yes, please list medications: _____________________________________
8. Have you ever been hospitalized because of a drug or alcohol problem? ___ Yes ___ No
   If yes, when and where? ____
9. Have you ever been to a detoxification program? ___ Yes ___ No
   If yes, when and where? ____
10. Have you ever been to a drug or alcohol rehabilitation program? ___ Yes ___ No
    If yes, when and where? ____
11. Have you ever attended a 12 step meeting such as AA, NA, Al-Anon, ACOA? ___ Yes ___ No
12. Have you ever used any street drugs (e.g., cocaine, marijuana, speed, LSD, etc)? ___ Yes ___ No
    If yes, please list all drugs: ____
13. Has anyone ever told you that drugs have caused a problem for you or complained about your drug use? ___ Yes ___ No
14. Has your use of drugs ever caused a relationship problem with anyone? ___ Yes ___ No
15. Has your use of drugs ever caused any problems at work or performing other responsibilities? ___ Yes ___ No
16. Has your use of drugs ever caused any legal problems? ___ Yes ___ No
17. Have drugs ever caused any physical problems such as headaches, shakiness, stomach aches, seizures or liver damage? ___ Yes ___ No
    If yes, please specify: ____
18. What was the longest period you have been drug free? __________ Approximate dates: ___________
19. When was the last time you used any drugs? __________________________
20. Has use of drugs ever caused any psychological problems such as depression? ___ Yes ___ No

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES

The following is the Notice of Privacy Practices of the Hudson Valley Center for Cognitive Therapy (HVCCT). HIPAA is a federal law that requires us to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy policies with respect to your protected health information. We are required by law to abide by the terms of this Notice of Privacy Practices.

Your Protected Health Information

Your "protected health information" (PHI) broadly includes any health information, oral, written or recorded, that is created or received by us, other healthcare providers, and health insurance companies or plans, that contains data, such as your name, address, social security or patient identification number, and other information, that could be used to identify you as the individual patient who is associated with that health information.

Rules on How We May Use or Disclosure Your Protected Health Information

Generally, we may not "use" or "disclose" your PHI without your permission, and must use or disclose your PHI in accordance with the terms of your permission. "Use" refers generally to activities within our office. "Disclosure" refers generally to activities involving parties outside of our office. The following are the circumstances under which we are permitted or required to use or disclose your PHI. In all cases, we are required to limit such uses or disclosures to the minimal amount of PHI that is reasonably required.

Without Your Written Authorization, Treatment, Payment and Health Operations

Without your written authorization, we may use within our office, or disclose to those outside our office, your PHI in order to provide you with the treatment you require or request, to collect payment for our services, and to conduct other related health care operations as follows:

Treatment activities include: (a) use within our office by our professional staff for the provision, coordination, or management of your health care at our office; and (b) our contacting you to provide appointment reminders or information about treatment alternatives or other health-related services that may be of interest to you.

Payment activities include: (a) if you initially consent to treatment using the benefits of your contract with your health insurance plan, we will disclose to your health plans or plan administrators, or their appointed agents, PHI for such plans or administrators to determine coverage, for their medical necessity reviews, for their appropriateness of care reviews, for their utilization review activities, and for adjudication of health benefit claims; (b) disclosures for billing for which we may utilize the services of outside billing companies and claims processing companies with which we have Business Associate Agreements that protect the privacy of your PHI; and (c) disclosures to attorneys, courts, collection agencies and consumer reporting agencies, of information as necessary for the collection of our unpaid fees, provided that we notify you in writing prior to our making collection efforts that require disclosure of your PHI.

Health care operations include: (a) use within our office for training of our professional staff and for internal quality control and auditing functions (b) use within our office for general administrative activities such as filing, typing, etc.; and (c) disclosures to our attorney, accountant, bookkeeper and similar consultants to our healthcare operations, provided that we shall have entered into Business Associate Agreements with such consultants for the protection of your PHI.

PLEASE NOTE THAT UNLESS YOU REQUEST OTHERWISE, AND WE AGREE TO YOUR REQUEST, WE WILL USE OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION FOR TREATMENT ACTIVITIES, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS AS SPECIFIED ABOVE, WITHOUT WRITTEN AUTHORIZATION FROM YOU.

Without Your Written Authorization, Special Situations and As Required By Law

In limited circumstances, we may use or disclose your PHI without your written authorization and in accord with HIPAA or as required by law. *Examples include*: (a) disclosures regarding reports of child abuse or neglect, including reporting to social service or child protective services agencies; (b) disclosures to State authorities of imminent risk of danger presented by patients to self or others for the purpose of restricting patient access to firearms; (c) health oversight activities including audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, or other lawful process; (e) to the extent necessary to protect you or others from a serious imminent risk of danger presented by you; (f) for worker's compensation claims, (g) as required by the Secretary of Health and Human Services to investigate or determine our compliance with federal regulations, including those regarding government programs providing public benefits, (h) for research projects where your PHI has been de-identified, that is no longer identifies you by name or any distinguishing marks, and cannot be associated with you, (i) to family members, friends and others involved in your care, but only if you are present and give oral permission

Minimum Necessary Rule: We will use or disclose your PHI without your authorization for the above purposes only to the extent necessary, and will release only the minimum necessary amount of PHI to accomplish the purpose.

All Other Situations, With Your Specific Written Authorization

Except as otherwise permitted or required as described above, we may not use or disclose your PHI without your written authorization. Written authorization is required, among other uses and disclosures, for (1) most uses and disclosures of Psychotherapy Notes, (2) uses and disclosures for marketing purposes, (3) uses and disclosures that involve the sale of PHI and (4) other uses and disclosures not described in this Notice. Further, we are required to use or disclose your PHI consistent with the terms of your authorization. You may revoke your authorization to use or disclose any PHI at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Special Handling of Psychotherapy Notes

"Psychotherapy Notes" are defined as records of communications during individual or family counseling which may be maintained in addition to and separate from medical or healthcare records. Psychotherapy Notes are only released with your specific written authorization except in limited instances, *including*: (a) if you sue us or place a complaint, we may use Psychotherapy Notes in our defense; (b) to the United States Department of Health and Human Services in an investigation of our compliance with HIPAA; (c) to health oversight agencies for a lawful purpose related to oversight of our practice; and (d) to the extent necessary to protect you or others from a serious imminent risk of danger presented by you. Health insurers may not condition treatment, payment, enrollment, or eligibility for benefits on obtaining authorization to review, or on reviewing, Psychotherapy Notes.

Your Rights With Respect to Your Protected Health Information

Under HIPAA, you have certain rights with respect to your PHI. The following is an overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your PHI. While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your protected healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law. If you have paid for our services in full yourself, out-of-pocket, then we must comply with your request to restrict those disclosures of your PHI that would otherwise be made for payment or healthcare operations, that are unnecessary because of your manner of payment. We require that all requests for restrictions be in writing and specify (1) the information to be restricted, (2) the type of restriction being requested, and (3) to whom the limits apply. You must also state a reason for the request. We will respond in writing to all requests within 30 days or receipt.

Right To Receive Confidential Communications By Alternative Means And At Alternative Locations

We must permit you to request and must accommodate reasonable requests by you to receive communications of PHI from us by alternative means or at alternative locations. We will ask you how you wish us to communicate with you. We must agree to your request if you inform us that certain of means of communicating with you will place you in danger.

Right To Inspect and Copy Your Protected Health Information, Including In Electronic Format

You have the right of access in order to inspect, and to obtain a copy of your PHI, including any PHI maintained in electronic format, *except for* (a) personal notes and observations of the treating provider, (b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, (c) health information maintained by us to the extent to which the provision of access to you is at our discretion, and we exercise our professional judgment to deny you access, and (d) health information maintained by us to the extent to which the provision of access to you would be prohibited by law.

We require written requests for copies of your PHI; they should be sent to our Privacy-Security Officer at the mailing address below. You may request your PHI in the format of your choice, and where feasible, we will comply. If you request a copy of your PHI, we will charge a fee for copying, or for electronic records, for labor and supplies. We reserve the right to deny you access to and copies of all or certain PHI as permitted or required by law. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the basis for denial, a statement of your rights, and a description of how you may file an appeal or complaint.

Right To Amend Your Protected Health Information

You have the right to request that we amend your PHI, for as long as your medical record is maintained by us. We have the right to deny your request for amendment. We require that you submit written requests and provide a reason to support the requested amendment.

If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us and/or the Secretary of the U.S. Department of Health and Human Services (DHHS). If we accept your request for amendment, we will make reasonable efforts to provide the amendment within a reasonable time to persons identified by you as having received PHI of yours prior to amendment and persons that we know have the PHI that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendments shall be sent to our Privacy-Security Officer at the mailing address below.

Right To Receive An Accounting Of Disclosures Of Your PHI And Electronic Health Records

You have the right to receive a written accounting of all disclosures of your PHI for which you have not provided an authorization that we have made within the six (6) year period immediately preceding the date on which the accounting is requested.

You may request an accounting of such disclosures for a period of time less than six (6) years from the date of the request. We require that you request an accounting in writing on a form that we will provide to you.

The accounting of disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, instead of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. *We are not required to provide accountings of disclosures for the following purposes*: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) to other healthcare providers involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/2003. We reserve the right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to our Privacy-Security Officer at the mailing address below.

If we maintain any PHI in electronic form, then you may also request and receive an accounting of any disclosures of your electronic health records made for purposes of treatment, payment and health operations during the prior three (3) year period. Upon request, one list will be provided for free every twelve (12) months.

Right To Notification If There Is A Breach of Your Protected Health Information If there is a breach in our protecting your PHI, we will follow HIPAA guidelines to evaluate the circumstances of the breach, document our investigation, retain copies of the evaluation, and where necessary, report breaches to DHHS. Where a report is required to DHHS, we will also give you notification of any breach.

Business Associate Rule

Business Associates are entities that in the course of our business with them will obtain access to your PHI. They may use, transmit, or view your PHI on our behalf. Business Associates are prohibited from re-disclosing your PHI without your written consent, or unless disclosure is required by law. We enter into confidentiality agreements with our Business Associates called Business Associate Agreements, and they in turn enter into confidentiality agreements with their subcontractors, if any.

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. Please submit any complaint to us in writing by mail to our Privacy-Security Officer at the mailing address below. A complaint must name the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Notice of Privacy Practices. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint. To file a complaint with the Secretary of DHHS, write or call: The US Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, SW, Washington, DC 20201, 877-696-6775.

Amendments to this Notice of Privacy Practices

We reserve the right to revise or amend this Notice of Privacy Practices at any time. These revisions or amendments may be made effective for all PHI we maintain even if created or received prior to the effective date of the revision or amendment. Upon your written request, we will provide you with notice of any revisions or amendments to this Notice of Privacy Practices, or changes in the law affecting this Notice of Privacy Practices, by mail or electronically within 60 days of receipt or your request.

Ongoing Access to Notice of Privacy Practices

We will provide you with a copy of the most recent version of this Notice of Privacy Practices at any time upon your written request sent to our Privacy-Security Officer at the mailing address below. For any other requests or for further information regarding the privacy of your PHI, and for information regarding the filing of a complaint, please contact us at the address or telephone number listed below.

To Contact Us

This is our contact information referred to above: Our Privacy-Security Officer is: Christine Ziegler, Ph.D. Our mailing address is: 421 North Highland Avenue, Nyack, NY 10960. Our telephone number is: (845) 353-3399. Our fax number is: (845) 353-2272.

Acknowledgment of Receipt

I hereby acknowledge that I have received, read, and understood this Notice of Privacy Practices, and that any questions I have had about it have been answered.

____________________	____________________	________
Print Name	Signature	Date