HUDSON VALLEY CENTER FOR COGNITIVE THERAPY
421 North Highland Avenue • Upper Nyack, NY 10960
(845) 353-3399 • Fax: (845) 353-2272 • http://www.hvcct.com

INFORMED CONSENT FOR TELEPSYCHOLOGY
(COVID-19)

This Informed Consent for Telepsychology contains important information regarding psychotherapy using the phone or the Internet. Please read this carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology
Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician is unable to meet in person. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. Examples include:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy, but it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

Confidentiality
I will make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. There is always a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should take reasonable steps to ensure the security of our communications (e.g., only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

Please note that the extent of confidentiality and the exceptions to confidentiality that I outlined in my Client Information and Office Policy Statement that you received at the outset of therapy still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Fees
The same fee will apply for telepsychology as apply for in-person psychotherapy. Payment arrangements will be discussed prior to the therapy session. The same cancelation policy applies in that cancelations are billed if they are within 24 hours of the scheduled appointment. It is our understanding that given the coronavirus (COVID-19) situation teletherapy sessions will be reimbursable. However, please contact your insurance company prior to our engaging in telepsychology sessions in order to verify this information.

Records
The telepsychology sessions should not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent (the Client Information and Office Policy Statement) and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

By typing your name below, you are signing this consent form electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this form.

Patient Signature:

Printed Name: **Date:**

Parent or Guardian Signature (if under 18 years old):

Printed Name: **Date:**

Therapist Signature:

Printed Name of Therapist: **Date:**

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 ABOVE POLICY STATEMENTS AND HEREBY SIGN.

By typing your name below, you are signing this consent form electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this form.

Signature:

Printed Name: **Date:**

Therapist's Signature: **Date:**

Personal Data Form

Name:

Address:

Phone Numbers:	OK to call		OK to leave message?	
Cell:	Yes	No	Yes	No
Home:	Yes	No	Yes	No
Work:	Yes	No	Yes	No

Email:

How were you referred to us?

Age: Birth date:

Gender:

Relationship Status:

Student: Yes No Full time Part time

Occupation: Full time Part time

Primary Care Physician and Phone Number:

Emergency Contact: Relationship:

Phone Number:

Please describe the reason(s) that you are seeking treatment at this time:

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 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 health in the past year? Yes No
   If yes, please specify:

5. Are you currently taking any medication (psychiatric, non-psychiatric, over the counter)?
   Yes No

   If yes, please list (Medication, Dosage/Frequency, Prescriber):

6. Does anyone in your family have a history of mental health issues (e.g., depression, anxiety, alcohol, or substance abuse)?
   Yes (Indicate family member(s) and nature of the problem):

   No

7. Have you ever had a history of (check all that apply):

High/ Low Blood Pressure	G/I Issues (List):
Seizures/Epilepsy	Diabetes
Tics	Cancer
Cardiac Problems	Asthma
Thyroid Problems	Other:

8. Please share any other information that you feel is relevant:

Psychiatric History

Name: Date:

1. Have you ever been hospitalized for any emotional or psychiatric reason? Yes No
   If yes, please indicate the dates, name of the hospital, and the reason for hospitalization

2. Have you ever received psychiatric or psychological treatment before? Yes No
   If yes, please indicate the dates, the name of the clinician, the reason for treatment, and if it was helpful.

3. Are you currently taking any medication for psychiatric reasons? Yes No
   If yes, please indicate the name of the medication, the dosage, frequency, and the name of the prescriber

4. Have you ever made a suicide attempt? Yes No
   If yes please indicate the date(s), what you did to hurt yourself and if you were 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. Has anyone in your family received psychiatric treatment? Yes No

8. Does anyone in your family have a history of mental health issues? Yes No
   If yes, please indicate the family member and the nature of the mental health issue:

9. Please list all psychiatric medications you have taken in the past.

10. Have you ever experienced abuse as a child? Choose an Item

11. Have you ever experienced abuse as an adult? Choose an Item

12. Have you ever experienced sexual abuse as a child? Choose an Item

13. Have you ever experienced rape including date or marital rape? Choose an Item

14. Have you ever experienced verbal abuse as a child? Choose an Item

15. Have you ever experienced verbal abuse as an adult? Choose an Item

Alcohol and Drug Use History

Name: Date:

1. When did you last drink alcohol?
2. Has alcohol ever caused any problems for you? Choose an Item
3. Has anyone ever told you that alcohol was a problem for you? Choose an Item
4. Has your use of alcohol ever caused a relationship problem with anyone? Choose an Item
5. Has your use of alcohol ever caused any problems at work or performing responsibilities? Choose an Item
6. Has your use of alcohol ever caused any legal problems such as being arrested or DUI? Choose an Item
7. Have you been dependent on medication or taken a lot more than prescribed? Choose an Item
   If yes, please list medications:
8. Have you ever been hospitalized because of a drug or alcohol problem? Choose an Item
   If yes, when, and where?
9. Have you ever been to a detoxification program? Choose an Item
   If yes, when,and where?
10. Have you ever been to a drug or alcohol rehabilitation program? Choose an Item
    If yes, when,and where?
11. Have you ever attended a 12-step meetingsuch as AA, NA, Al-Anon, ACOA? Choose an Item
12. Have you ever used any street drugs (e.g., cocaine, marijuana, speed, LSD, etc)? Choose an Item
    If yes, please list all drugs:
13. Has anyone ever told you that drugs have caused a problem for you? Choose an Item
14. Has your use of drugs ever caused a relationship problem with anyone? Choose an Item
15. Has your use of drugs ever caused anyproblems at work or performing other responsibilities? Choose an Item
16. Has your use of drugs ever caused any legal problems? Choose an Item
17. Have drugs ever caused any physical problems such as headaches, shakiness, seizures etc.? Choose an Item
    If yes, please specify:
18. What was the longest period you have been drug free? Dates:
19. When was the last time you used any drugs?
20. Has use of drugs ever caused any psychological problems such as depression? Choose an Item

HUDSON VALLEY CENTER FOR COGNITIVE THERAPY
421 North Highland Avenue • Upper Nyack, NY 10960
(845) 353-3399 • Fax: (845) 353-2272 • http://www.hvcct.com

HVCCT Electronic Communication Consent Form

In order to facilitate timely and efficient communication, you may elect to have our office communicate with you electronically via email and/or text (depending on your therapist's preference). Content of these messages may contain, but is not limited to, appointment times, release forms, invoices, receipts, and other financial information. In addition, you and your therapist may agree to use other forms of electronic communication, such as Google Drive, and assessment programs, such as Qualtrics.

With that said, it is important to understand the following about electronic communication:

1) Complete security and confidentiality with email communication cannot be guaranteed.

2) Electronic messages, besides those regarding administrative issues, may become a part of your record.

3) Although our office will endeavor to read and respond promptly to all messages, we cannot guarantee that your electronic communication will be read and responded to within any particular period of time. If your message invites a response from the therapist and a response is not received within a reasonable time period, it is your responsibility to follow up.

4) You are responsible for protecting the security on your computer or cell phone.

5) It is important to note that electronic communication should never be used for emergencies or other time-sensitive matters.

Thus, patients must consent to the use of electronic communication. If you do agree to send and receive information electronically, 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 and/or failure to respond in a timely manner.

Please be sure to let us know at any time if there is any information that you would not want to be communicated electronically.

By typing your name below, you are signing this consent form electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this form.

Printed Name: _____

Signature of Patient (or Parent/Guardian if under 18): _____

Date: _____

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.

By typing your name below, you are signing this consent form electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this form

Print Name:

Signature:

Date:

Doxy.me Instructions for Patients

Users must use Firefox or Google Chrome web browsers. You will need to first install one of these on your computer, if you haven't already. Go to https://getfirefox.com or https://www.google.com/chrome/.

You do not need to create a doxy.me account. However, for the first time only, you will need to give permission for your browser to access your microphone and camera.

Doxy.me can be used on a desktop computer or a tablet or phone.

Using Firefox or Google Chrome, go to the URL provided by your therapist.

The "**Check In**" box will appear. Enter your name and click **"Check In"** so your therapist knows you have arrived. The therapist will start the call at your scheduled time.

HUDSON VALLEY CENTER FOR COGNITIVE THERAPY
421 North Highland Avenue • Upper Nyack, NY 10960
(845) 353-3399 • Fax: (845) 353-2272 • http://www.hvcct.com

Online Payment Options

For those who prefer to pay electronically, we offer two methods of online payments. If you choose to send payments electronically, payments must be received before the session or be sent from your mobile device at the time of session.

1. Zelle: Zelle allows you to pay for sessions directly from your bank account using your bank's website or through Zelle's website or app if your bank is not a member of the network. You can register for online payments through your bank's website (if your bank participates) or you can register on the Zelle app. Most larger banks seem to participate. **After you complete their registration, you will be able to send money to the Center using the e-mail address "ziegler@hvcct.com" as the payee. Please note that it will ask you if PALISADES PSYCHOLOGICAL is correct and it is.**

If you need assistance and you're using Zelle through your bank's website or app, please contact your financial institution's support team directly. If you're using the Zelle app, you can contact them at 844-428-8542.

2. Venmo: By using Venmo (available on iPhone iOS, Android, Mac and Windows), you can transfer funds directly from your bank account, debit card, or credit card. To do so, download the free app on your phone or visit the Venmo website and set up an account. **The Center's Venmo username is HVCCT**. Do not use our phone number or search for or send payments to your therapist. Payments should be sent to HVCCT. If for some reason you are asked for a phone number, do not use the center's phone number. Please contact Dr. Ziegler.

If you wish to transfer the funds from your credit card, Venmo will charge you a service charge. This charge goes to Venmo and is neither assessed nor received by the HVCCT. The pricing structure is determined by Venmo, and any future changes to this pricing structure are also determined by Venmo.

We strongly encourage you to set up privacy settings on your account. To do so, go to **Settings**, then to **Privacy & Sharing**, and set the audience to **"Participants Only."** Next choose to make all past transactions **Private**. There are other privacy options on this page that you can investigate as well. Although Venmo is widely used and considered safe, Venmo users assume any potential security risks just as they would by using any other financial app.

If you have any difficulties with Venmo transfers, you need to address them with Venmo. Venmo customer service can be reached at 855-812-4430.