MARIA DROSTE
COUNSELING SERVICES
BRINGING HOPE TO LIFE

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND 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. 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 my 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 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

Without Your Authorization

Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the following categories.

- **For Treatment.** Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services in our practice. For example, information obtained from a member of your health care treatment team will be recorded in your record and used to determine the course of treatment for you. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant or health care provider only with your authorization.
- **For Payment.** We may use and disclose PHI so that we can receive payment from you, an insurance company or a third party, for the services we have provided to you. For example, we may need to give your health plan information about treatment you received from our clinic so

your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive in order to obtain prior approval for the service. The information disclosed will be limited to the nature of services provided, the dates of services, the amount due and other relevant financial information. 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 your PHI for health care operations. These uses and disclosures are necessary to run our practice and make sure that all of our clients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. For employee training or teaching purposes PHI will be disclosed only with your authorization. We may use PHI to reschedule or remind you of appointments. You have the right to request that we call or write you only at your home or your work or prefer some other way to reach you.
- **Judicial and Administrative Proceedings.** In any judicial or administrative proceeding, you have the right to refuse to authorize the disclosure of any communication between you and a social worker relating to your care and treatment. There are a few instances in which this privilege would not apply, and therefore, in which we could testify in the judicial or administrative proceeding. Specifically, we may disclose such communications during judicial or administrative proceedings, if (i) we determine that you need hospitalization or are a threat to yourself or to others; (ii) the communications were made in the course of a court-ordered psychiatric examination; (iii) you are a party to a case and you have introduced your mental or emotional state as an element of a claim or defense; (iv) if the testimony is given in connection with a care and protection proceeding, or a petition to dispense with parental consent to adoption; (v) in connection with any malpractice action brought by you against us, where the disclosure is necessary for our defense; (vi) if the communications relate to your ability to provide care or custody in a child custody or adoption case; or (vii) if the communication were made in connection with and during an investigation of allegations of child abuse, when we have made a report that we have reasonable cause to believe that child abuse is occurring; or (viii) if we believe a child, a disabled person, or an elderly person in your care is suffering abuse or neglect.
- **In an Emergency.** We may disclose your PHI to a physician who requests such records in the treatment of a medical or psychiatric emergency. For example, if you are unconscious and the doctor treating you needs to know details regarding your medical history in order to decide on a course of treatment for you, we would disclose the PHI necessary for the doctor to treat you during the emergency. If it is not possible to obtain your consent to this disclosure, then notice of the disclosure will be provided to you as soon as possible.
- **As Required by Law.** We may disclose your PHI as required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations.
- **If Required by Court Order.** We may disclose your PHI in a judicial proceeding if required by Court order.
- **If Necessary Because of Threat to Health or 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. We may use or disclose your PHI to the extent which is necessary to protect your safety or the safety of others, if (1) you present a clear and present danger to yourself, or (2) you have

communicated an explicit threat to kill or inflict serious bodily injury upon another person, and there is a basis for reasonable belief that the threat may be carried out. 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.

- **Business Associates.** Some services in our organization we obtain through contracts with business associates. For example, we may contract with outside companies to provide legal services, accounting services, or billing services. When we contract with a business associate, we may disclose health information to the business associate so it can do the job we've asked it to do. To protect your health information, we require the business associate to appropriately safeguard your health information.

With Your Authorization

Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization.

- **Revocation of Authorization.** If you provide us with permission to use or disclose PHI about you, you may revoke that permission, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the purposes covered by the written authorization. However, we are unable to take back any disclosures that we have already made with your authorization.

YOUR RIGHTS REGARDING YOUR PHI

You, or your authorized representative, have the following rights regarding PHI that we maintain about you. To exercise any of these rights, please submit your request in writing to me.

- **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 may be 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 be reasonably likely to endanger the life or physical safety of you or another person. We may charge a reasonable, cost-based fee for copies. We will act on your request within thirty days of receiving your request.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us in writing to amend the information although we am not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of the disclosures that we make of your PHI. This is a list of certain disclosures we have made of your PHI. To make this request, you should submit it in writing to me. 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 medical information we use or disclosure about you for treatment, payment, or health care operations. For example, you might request that particularly sensitive information (such as the

existence of drug dependence) not be disclosed for any purpose. We are not required to agree to your request. To request restrictions, you must submit your request in writing to me. In your request, you must tell me (1) what information you want to limit, (2) whether you want to limit the use, disclosure, or both, and (3) to whom you want the limits to apply (for example, disclosures to your insurance carrier.)

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
- **Right to a Copy of this Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT US AT (617) 471-5686.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing or call us at (617) 471-5686 or file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services, Government Center, J.F. Kennedy Federal Building--Room 1875, Boston, Massachusetts 02203. Voice phone (617) 565-1340. FAX (617) 565-3809. TDD (617) 565-1343.We will not retaliate against you for filing a complaint.

My signature below signifies that I have read and understand these Privacy Practices:

Note for Minors: *If the client is a person under the age of 18 years-old, in the case of divorced or separated parents, both parents are required to sign (either this or a separate copy of) this document before treatment can begin.*
Note for Couples: *If you are coming for couples (relational) therapy, both you and the significant other are required to sign (either this or a separate copy of) this document before treatment can begin.*

_____ _____

Signature of Client or Parent/Guardian Date

_____ _____

2nd Parent (Joint Custody) Signature (if Client is under 18) Date
Or 2nd Partner for Couples Therapy

Client Information Sheet

MISSION

Maria Droste Counseling Services (MDCS) provides mental health & substance abuse counseling and was begun in 1992 by the Sisters of The Good Shepherd, a women's Catholic religious organization. Although the number of sisters active in the mission is reduced today and we are now led by a "lay" staff of women and men, the original mission continues and that is: to help individuals, couples, and families who are experiencing difficulties at home, work, school, or in relationships to find healing and reconciliation within themselves and one another through our services. We welcome people of all religions, races, nationalities, and belief systems. We turn no one away because of inability to pay and only refer out to another organization when we are unable to provide the needed services. We believe each person has the potential for emotional growth and to live with a sense of well-being and we are committed to help make this a reality in our client's lives. Services are provided by licensed and trained staff and volunteers as well as interns who are on their way to licensure and for whom an internship is required by their university and Massachusetts law.

EMERGENCIES & AFTER-HOUR COVERAGE

We will provide after-hours coverage to active clients who are facing a crisis or experiencing an emergency. Clients should call our phone number where they will either speak with a therapist during normal hours of operation or, during after-hours, they will be given the option to connect to our emergency line which will either be picked up by the on-call emergency service therapist or they will be called back within 15 minutes. Other options include calling your local emergency service provider, dialing 911, or getting yourself to a hospital emergency room. In the Quincy area you may also call Aspire Health Alliance at 617-774-6036 or 800-528-4890. Please discuss with your clinician ahead of time any anticipated need for emergency services, if possible.

ASSESSMENT/TREATMENT

We offer short and longer-term mental health therapy to individuals, couples, families, and also adolescents and children on an outpatient basis. We also offer a variety of holistic therapies, such as massage therapy, Reiki, Biodynamic Craniosacral Therapy, Polarity therapy and other "energy work" according to the specific skill sets of individual clinicians. All new mental health clients are given a diagnostic assessment in their first session and up to three sessions to determine the course of treatment and whether a referral needs to be made. If our assessment reveals the need for a higher level of care or requires a skillset not offered by our current staff, a referral to an appropriate setting will be offered to the client.

FEES

Payments are accepted by cash, check made out to "Maria Droste," or credit card and are handled by your individual therapist. We take some insurances and offer a sliding fee scale to those whose insurances we do not take, those who have no health insurance, and those whose insurances we do take but who cannot afford their deductibles or copays. Please review your financial needs with your individual therapist. Our

mission is to not turn anyone away over payment issues. We do appreciate our clients paying what they can afford to help us offset costs and keep our doors open for all. We offer a payment plan in addition to our reduced fees.

CANCELLATIONS/NO-SHOWS & CASE CLOSINGS

A prerequisite for treatment is that you demonstrate motivation to receive services from us by coming on time to appointments and not canceling or "no-showing" appointments regularly. The charge for a no-show is $50 or the agreed-upon rate made ahead of time. It is up to each individual therapist to charge you or not for missed appointments. Please note that if there are any safety or conduct concerns we have, therapy may be terminated, and we will offer a referral elsewhere. Also, If we do not have contact or communication from you for a period of 30 days, unless previously discussed with your therapist, we will assume that you no longer intend to remain active in this therapeutic relationship and your case will be closed. You can return to therapy and your case will be reopened if you decide to continue treatment at a later date. However, if there are too many cancellations or no-shows, we may refuse further services and/or your case will be closed after 30 days but we will offer a referral elsewhere if you have called asking to return. We do not wish to charge anyone for a session they did not attend nor do we wish to refuse services to anyone, but we also need to honor the many clients who conscientiously show up for their therapy and others who are waiting for our services.

I have read the above and have discussed my questions or concerns regarding these policies. I understand and consent to receive services in accordance with these policies.

Note for Minors: *If the client is a person under the age of 18 years-old, in the case of divorced or separated parents, both parents are required to sign (either this or a separate copy of) this document before treatment can begin.*
Note for Couples: *If you are coming for couples (relational) therapy, both you and the significant other are required to sign (either this or a separate copy of) this document before treatment can begin.*

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Signature of Client or Parent/Guardian Date

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2nd Parent (Joint Custody) Signature (if Client is under 18) Date
Or 2nd Partner for Couples Therapy