

Global Therapy, Inc

333 N. Broadway
Booneville, AR 72927

**OFFICE POLICIES & GENERAL INFORMATION
AGREEMENT FOR PSYCHOTHERAPY SERVICES**

This form provides you (patient) with information that is additional to that detailed in the Notice of Privacy Practices.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law

When Disclosure Is Required By Law: Reasonable suspicion of child, dependent or elder, abuse or neglect; and where a client presents a danger to self, to others, to property, or is gravely disabled.

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony.

Emergencies: If there is an emergency during our work together, or in the future after termination, where Mrs. Hunter becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, she will do whatever she can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, she may also contact the person whose name you have provided as an emergency contact

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance.

Confidentiality of E-mail, Cell Phone and Faxes Communication: Please notify Mrs. Hunter at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use e-mail or faxes for emergencies.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on Mrs. Hunter to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. **Should you subpoena testimony there will be a charge of \$500 per day.**

Consultation: Mrs. Hunter consults regularly with other professionals regarding his/her clients; however, the client's name or other identifying information is never mentioned.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact Mrs. Hunter between sessions, please leave a message on voice mail 479-431-4237 and your call will be returned as soon as possible. If an emergency situation arises, please indicate it clearly in your message. If you need to talk to someone right away, you can call the 24-hour crisis line 813-234-1234 Tampa, Fl or (479) 521-1532 Ft. Smith AR the 24-hour Mental Health Care 813-272-2244. (Tampa Florida) Western Arkansas Counseling and Guidance Center 24-Hour Emergency #: 1-800-542-1031 (Catchment Area 5 Arkansas) or the Police (911),

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay the standard fees set forth in the client agreement.

COLLECTIONS: Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, Mrs. Hunter can use legal means (court, collection agency, etc.) to obtain payment.

THE PROCESS OF THERAPY/EVALUATION: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits; however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Mrs. Hunter will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. Mrs. Hunter may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, Mrs. Hunter is likely to draw on various psychological approaches according, in part, to the problem that is being treated and his/her assessment of what will best benefit you. These approaches include behavioral, cognitive-behavioral, psychodynamic, existential, system/family, developmental (adult, child, family), or psycho-educational.

Discussion of Treatment Plan: Mrs. Hunter will discuss with you (client) his/her working understanding of the problem, treatment plan, therapeutic objectives, and his/her view of the possible outcomes of treatment. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that Mrs. Hunter does not provide, she has an ethical obligation to assist you in obtaining those treatments.

Termination: As set forth above, after the first couple of meetings, Mrs. Hunter will assess if he can be of benefit to you. Mrs. Hunter does not accept clients who, in his/her opinion, she cannot help. In such a case, she will give you a number of referrals that you can contact. If at any point during psychotherapy, Mrs. Hunter assesses that s/he is not effective in helping you reach the therapeutic goals, she is obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, she would give you a number of referrals that may be of help to you. You have the right to terminate therapy at any time. If you choose to do so, Mrs. Hunter will offer to provide you with names of other qualified professionals whose services you might prefer.

Dual Relationships: Tampa is a small community and many clients know each other and Mrs. Hunter from the community. Consequently you may bump into someone you know in the waiting room or into Mrs. Hunter out in the community. Mrs. Hunter will never acknowledge working therapeutically with anyone without his/her written permission. It is your, the client's, responsibility to communicate to Mrs. Hunter if the dual relationship becomes uncomfortable for you in any way.

CANCELLATION: Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 1 day/ 24 hours) notice is required for re-scheduling or canceling an appointment. Insurance companies do not reimburse for missed sessions. A fee of \$55 will be charged for all appointments not cancelled within 24 hours.

Global Therapy, Inc
333 N. Broadway Booneville, AR 72927
HIPAA NOTICE OF PRIVACY PRACTICES

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

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. You may request a copy of this Notice from me, or you can view a copy of it in my office or on my website, which is located at <http://www.Global-Therapy.com>

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:

1. **For treatment.** I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care.
2. **For health care operations.** I may disclose your PHI to facilitate the efficient and correct operation of my practice. I may also provide your PHI to my attorneys, accountants, consultants, to make sure that I am in compliance with applicable laws.
3. **To obtain payment for treatment.** I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you.
4. **Other disclosures.** Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.**
2. **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**
3. **If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**
4. **If disclosure is compelled by the patient or the patient's representative pursuant to Florida Health and Safety Codes or to corresponding federal statutes of regulations**
5. **To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.
6. **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**
7. **If disclosure is mandated by the Florida and Arkansas Child Abuse and Neglect Reporting law.**
8. **If disclosure is mandated by the Florida and Arkansas Elder/Dependent Adult Abuse Reporting law.**
9. **If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.**

10. **For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. **For health oversight activities.** Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. **For specific government functions.** Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
14. **For Workers' Compensation purposes.**
15. **Appointment reminders and health related benefits or services.**
16. **If an arbitrator or arbitration panel compels disclosure..**
17. **I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that may be of interest to you.**
18. **If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.**
19. **If disclosure is otherwise specifically required by law.**

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to Inspect and Copy. You have the right to receive copies of your mental health information, however, **psychotherapy notes are exempt** from this right. I will charge \$5.00 per page for copying, mailing and supplies. Under limited circumstances, your request may be denied; you may request a review of the denial, which will be performed by another licensed mental health professional chosen by this office. Our office will comply with the outcome of the review.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. I am not legally bound to agree. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address or by an alternate method. I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.

D. The Right to Get a List of the Disclosures I Have Made.

E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing.

F. The Right to Get This Notice. You have the right to request a paper copy of this notice

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the office for Civil Rights- Region I, US Department of Health and Human Services JFK Federal building Room 1875, Government Center, Boston, MA 02203. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

Donna M. Hunter, LCSW, CAP 333 N. Broadway Booneville, AR, 72927 (419)431-4237

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003. Revised February 23, 2011

Global Therapy, Inc
4023 N. Armenia Ave Suite 102
Tampa, Fl 33603

I have received a copy of the Agreement and Office Policies and General Information and the HIPAA notice of Privacy Policy. I understand these policies are the binding policy and procedures installed by Global Therapy, Inc.

Client name (print)	Date	Signature
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Client name (print)	Date	Signature
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Therapist	Date	Signature
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