POLICY STATEMENT

Please read the following important information.

I. ELIGIBILITY FOR SERVICE

Mental health and chemical dependency services are not denied to any person on the basis of race, color, gender, sexual orientation, creed, handicap, national origin, duration of residence, or age.

II. APPOINTMENTS

1. All services are provided by appointment. Following your initial interview, any additional appointments will normally be arranged and scheduled by your provider (Therapist).

2. Please check in with the office personnel and make any payments when you arrive for your appointment. Providers may choose to reschedule your appointment if co-payment/deductible is not paid.

3. A 24-hour advance notice MUST be given for cancelled appointments. If you do not show up for your appointment as scheduled or you cancel with less than 24-hour notice, you will be charged $75.00 for the time reserved for you. Insurance companies will not reimburse for sessions that you do not attend. Payment for the fee will be expected **on or before you next session**.

4. To make, change, or cancel an appointment, please call your therapist.

III. PAYMENT OF FEES

1. It is customary to pay for professional services when rendered. Payment of fees should be made at the beginning of the scheduled appointment. Consistent payment must be made or services may be discontinued. Forms of payment accepted are cash (exact change only) or check.

2. If services are covered by insurance, your therapist will bill your insurance company directly. It is your responsibility to inform your therapist about any changes to insurance coverage, eligibility or personal address change. You are responsible to pay at the time of service any amounts due in order to cover any deductibles or co-payments that may be required by your insurance company.

3. SECONDARY INSURANCE –You are responsible for the secondary billing for all other insurance companies.

NOTE - You may obtain the necessary information for secondary billing from your primary insurance carrier.

4. If you have a balance on your account, you will receive a statement. All accounts are due and payable within thirty-days of notification.

5. If you have questions regarding the payment of fees, please discuss this with your provider. Discuss with your provider any concerns or problems you have in paying your account BEFORE it becomes delinquent.

6. If a client fails to be responsible for the account, and it is necessary to place a delinquent account into the hands of a collection agency/attorney, the client agrees to pay all court costs affixed by the court.

7. All checks made payable to: Patti Di Giacinto, LCSW, CADC.

8. There is a $21.00 service charge for NSF/Return checks.

IV. EMERGENCIES

Please check with your provider for the phone number and procedures for calling in a crisis situation.

V. GRIEVANCE PROCEDURE

If you are not satisfied with the services rendered to you, you may discuss your complaint with your provider to resolve the problem/issue. If you are unsatisfied with the resolution, you may appeal to the Illinois Department of Professional Regulation.

NOTICE OF PRIVACY PRACTICES
KEEP THIS COPY FOR YOUR RECORDS

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

I. Who We Are

This Notice describes the privacy practices of **Patti Di Giacinto , LCSW, CADC.** It applies to services furnished to you at 2030 Algonquin Road, Suite 401 Schaumburg, Illinois.

II. Our Privacy Obligations

We are required by law to maintain the privacy of your health information ("**Protected Health Information**" or "**PHI**") and to provide you with this Notice of our legal duties and privacy practices with respect to your Protected Health Information. When we use or disclose your Protected Health Information, we are required to abide by the terms of this Notice (or any other notice in effect at the time of the use or disclosure).

III. Permissible Uses and Disclosures without Your Written Authorization

In certain situations, which will be described in Section IV below, we must obtain your written **consent or** authorization ("**Your Authorization**") in order to use and/or disclose your PHI. However, unless the PHI is Highly Confidential Information (as defined in Section IV.C below) and the applicable law regulating such information imposes special restrictions on us, we may use and disclose your PHI without Your Authorization for the following purposes:

A. Treatment, Payment and Health Care Operations.

We may use and disclose PHI, in order to treat you, obtain payment for services provided to you and conduct health care operations as detailed below: (Patti Di Giacinto , LCSW, CADC policies and procedures require that your written consent/authorization is obtained in order to disclose most PHI).

i. Treatment. We may use and disclose your PHI to provide treatment and other services to you--for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also disclose PHI to other providers involved in your treatment. (Patti Di Giacinto LCSW, CADC policies and procedures require that your written consent/authorization is obtained in order to disclose most PHI).

ii. Payment. We may use and disclose your PHI to obtain payment for services that we provide to you from Medicare, the Illinois Medicaid program or another governmental program that arranges or pays the cost of some or all of your health care. We will obtain Your Authorization to disclose PHI to your private health insurer, HMO or other private payor.

iii. Health Care Operations. We may use and disclose your PHI for health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that is delivered to you. For example, your PHI may be used to evaluate the quality and competence of our psychologists, social workers and other health care workers.

B. Disclosure to Relatives, Close Friends and Other Caregivers. We may use and disclose your PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if (1) your agreement is obtained; (2) you are provided with the opportunity to object to the disclosure and you do not object; or (3) it is reasonably inferred that you do not object to the disclosure.

If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, professional judgment will be exercised to determine whether a disclosure is in your best interests. If your information is disclosed to a family member, other relative or a close personal friend, only information that is directly relevant to the person's involvement with your health care or payment related to your health care will be disclosed. We may disclose your PHI in order to notify (or assist in notifying) such persons of your location, general condition or death.

C. Public Health Activities. We may disclose your PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to the Illinois Department of Children and Family Services or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

D. Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose your PHI to the Illinois Department of Children and Family Services, the Illinois Department of Human Services or other governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

E. Health Oversight Activities. We may disclose you PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

F. Judicial and Administrative Proceedings. We may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process. Further, unless specifically authorized by a court order, your PHI may not be used or disclosed identifying you as a recipient of substance abuse program services if the purpose is to initiate or substantiate any criminal charges against you or to conduct any investigation of you.

G. Law Enforcement Officials. We may disclose your PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

H. Decedents. We may disclose your PHI to a coroner or medical examiner as authorized by law.

I. Health or Safety. We may use or disclose your PHI to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

J. Specialized Government Functions. We may disclose your PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.

K. Workers' Compensation. We may disclose your PHI as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

L. As required by law. We may use and disclose your PHI when required to do so by any other law not already referred to in the preceding categories.

IV. Uses and Disclosures Requiring Your Written Authorization

For any purpose other than the ones described above in Section III, we may use or disclose your PHI only when you give Your Authorization on our consent or authorization form.

A. Private Payors. Your Authorization must be obtained to disclose PHI to your HMO, health insurer or other private payor.

B. Uses and Disclosures of Your Highly Confidential Information. In addition, federal and Illinois law imposes special privacy protections for "**Highly Confidential Information**"), which is Psychotherapy Notes and the subset of Protected Health Information that is related to: (1) treatment of a mental illness; (2) alcohol and drug abuse treatment program services; (3) HIV/AIDS testing; (4) child abuse and neglect; (5) sexual assault; and (6) genetic testing. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by laws regulating Highly Confidential Information, Your Authorization must be obtained.

V. Your Rights Regarding Your Protected Health Information

A. For Further Information; Complaints. If you desire further information about your privacy rights, are concerned that your privacy rights have been violated or disagree with a decision that was made about access to your PHI, please speak with your provider regarding the matter. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services.

B. Right to Request Additional Restrictions. You may request restrictions on the use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While all requests for additional restrictions will be considered carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from your provider and submit the completed form to your provider. We will send you a written response.

C. Right to Receive Confidential Communications. You may request and be accommodated with any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

D. Right to Revoke Your Authorization. You may revoke Your Authorization, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to your provider. A form of Written Revocation is available upon request from your provider.

E. Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, access may be denied to a portion of your records. If you desire access to your records, please obtain a record request form from your provider. If you request copies, we will charge you **$0.10** for each page. We will also charge you for our postage costs, if you request that we mail the copies to you. If you request a summary of your PHI, we will charge you $25.00 per hour for each summary.

F. Right to Amend Your Records. You have the right to request amendments to your Protected Health Information maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from your provider. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

G. Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 25, 2014. If you request an accounting more than once during a twelve (12) month period, we will charge you $0.10 for each page of the accounting statement.

H. Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

VI. Effective Date and Duration of This Notice

A. Effective Date. This Notice is effective on: April 25, 2014.

B. Right to Change Terms of this Notice. The terms of this Notice may be changed at any time. If this notice is changed, the new notice terms effective for all Protected Health Information that is maintained, including any information created or received prior to issuing the new notice. If this Notice is changed, the new notice will be posted in waiting areas.

INFORMED CONSENT FOR TREATMENT AND EVALUATION

You have certain rights and responsibilities when consulting a psychologist, psychiatrist, nurse practitioner, psychotherapist, social worker, or counselor for treatment or evaluation:

1. You have the **RIGHT TO BE INFORMED REGARDING THE TERMS UNDER WHICH TREATMENT OR EVALUATION WILL BE PROVIDED**. Policies related to charges, billing third party payors, appointments, emergencies, and coverage for when your therapist is unavailable, and other matters will be explained or provided to you. It is your responsibility as a client to stay informed.
2. You have the **RIGHT TO CHOOSE THE BEST TREATMENT AND PROVIDER**. There are a variety of professionals offering counseling, psychotherapy, psychiatric evaluations. There are also a number of different approaches to working with human issues. It is your right and responsibility to choose the treatment and provider that best match your needs and to participate in the development and periodic review of an individualized treatment plan. You also have a right to a detailed explanation of any treatment or procedure your provider may choose to use including the risks involved and the side-effects if any. If you believe you are not receiving the treatment you require, then raise this concern with your therapist or provider and s/he will work with you to revise your treatment plan or to refer you to other professionals who may be able to meet your needs.
3. You have the **RIGHT TO KNOW THE QUALIFICATIONS AND TRAINING** of your provider. You may request a therapist information sheet from your provider. If you have concerns, complaints, or believe a breach of professional conduct has occurred, you may contact the vice president or his designee to discuss the problem. Every attempt will be made to resolve the difficulty so that treatment may continue unhindered. If the difficulty is not resolved, you have the right to make a formal complaint to the relevant licensing agency.
4. You have the **RIGHT TO REFUSE TREATMENT OR TO STOP TREATMENT** at any time and for any reason. In the case where a minor is the patient/client, then the parent(s) or legal guardian has the right to refuse or stop treatment for the minor. You also have the right to refuse or stop evaluations. Your provider also has the right to refuse or terminate treatment, in which case you will be provided with alternatives. It is our hope that if you have concerns regarding your treatment or wish to discontinue you will discuss this with your provider.
5. You have the **RIGHT TO YOUR DIAGNOSIS**. This means that after your initial mental health assessment, the treatment provider will provide the client with his/her initial diagnosis or provisional diagnosis.
6. You have the **RIGHT TO CONFIDENTIALITY**. This means that what you tell your therapist or provider and what is contained in your clinical file will not be repeated or released by the therapist to anyone else without your expressed permission (i.e. by a signed release of information). You have the right to see and have access to the contents of your file. You have the right to discuss your own therapy or evaluation with anyone you choose, including another provider. The content within group therapy is confidential and may not be shared with anyone outside of the group.
7. For minors 14-17 years old. Therapists may provide treatment to a fourteen year old without the consent of his or her parent. Illinois law requires your therapist to have your parents involved in treatment before the end of treatment unless there are clear clinical indications to the contrary, which must be documented in your clinical chart. Your therapist does not need to involve your parents in treatment if you have been sexually abused by your parent, or if you are emancipated. It is the policy of Patti Di Giacinto , LCSW, CADC to notify the parents on or before the third (3) sessions. It is the policy of Patti Di Giacinto, LCSW, CADC to require both you and your parents to sign any release of information to anyone other than your parents.

There are, however, some limits and exceptions to complete confidentiality:

a. **CHILD OR ELDER ABUSE**: Generally, providers are required by law to report any known or suspected cases of child or elder abuse to the Children's Services Division or other appropriate state agency.

b. **VIOLENCE**: If a provider learns that someone is about to kill or to do harm to someone else, s/he will do her/his best to warn the intended victim.

c. **SUICIDE**: If a provider learns that a client intends to harm his/her self, the provider will breach confidentiality to the extent necessary for his/her protection.

d. **NON-CUSTODIAL PARENTS**: By law, non-custodial parents can gain access to their children's records pertaining to treatment or evaluations.

e. **SUPERVISON**: If you are seeing an unlicensed therapist (e.g., a master's level counselor, psychology intern, or a psychologist resident, etc.) then it is expected that your therapist will initially present your case in a clinical staffing and also periodically review and discuss your treatment with a supervisor. You will be informed as to who the supervisor is prior to receiving treatment or evaluation.

f. **CONSULTATION**: Occasionally, it is in your best interest for your provider to consult other providers regarding your treatment (e.g., medication issues, family issues, obtaining another's expert opinion, covering emergency phone calls, etc.). In cases where consultation with another professional is required, then your written consent will be obtained.

g. **INSURANCE**: Insurance companies or their designated management company may require information about your diagnosis, treatment history, prognosis, treatment, or other relevant information in order to authorize services or process claims. A release of information will be obtained for this if you are utilizing an insurance company.