Angela Sadowski Counseling Services

Demographic Information

Type of therapy: (Check all that you think would be beneficial.)
___ Individual ___ Family
Client Name: _____SSN#_____ Date of Birth: _____
Parent Name (If Minor) _____ ___ Date of Birth: _____
Parent Name (IF Minor): _____ _____ Date of Birth: _____
Spouse Name or Significant Other: ____ _____ Date of Birth: _____
If a child under the age of 18 will be involved in therapy, who holds custodial guardianship?
_____

Address: _____ Ok to Send Mail: ___ yes ___ no
Phone Number(s)
Name Phone Number Type (Home/Cell) Can I Leave a Message?
_____ _____ _____ __ yes __ no
_____ _____ _____ __ yes __ no
Clients may choose to email Angela for routine matters such as scheduling an appointment. Angela will always attempt to contact clients by phone before sending an email. Please do not send last minute session cancellations by email. Please call Angela with this information. Please note that Angela does not use an encrypted email system and therefore, will not send protected health information (completed intake forms, reports, etc.) by email nor will she discuss the content of therapy sessions via email. The privacy of client protected health information cannot be guaranteed when communicating via the internet.
Ok to Email: ___ yes ___ no Email Address: _____

Employment Info: _____
Number of people in the household: _____
Professional Contacts (list all that apply)
Physician: _____ Phone: _____
Psychiatrist: _____ Phone: _____
Probation Officer: _____ Phone: _____
Caseworker: _____ Phone: _____
School: _____ Phone: _____
Other: _____ Phone: _____

What is the reason that you are seeking therapy at this time?
_____
_____
_____

By signing below, I attest that I have discussed the various types of communication that are acceptable for my family. I understand the risk to my privacy should I choose to email with my therapist. Angela Sadowski, MSW, CSW-PIP, QMHP from any and all liability should I choose to communicate with her via email.

_____ _____
Client Signature Parent Signature Date

_____ Date_____ _____
Parent Signature

Angela Sadowski Counseling Services

Consent for Treatment

Client's Name: _____
Client's Date of Birth: _____

I authorize and request that Angela Sadowski, MSW, CSW-PIP, QMHP provide psychological treatment for myself, my child and/or my family. The frequency and type of treatment will be decided in conjunction with Angela Sadowski, MSW, CSW-PIP, QMHP. I understand that the purpose of these procedures will be explained to me and are subject to my verbal agreement.

I understand that there is an expectation that I will benefit from psychotherapy but that there can be no guarantee this will occur. I understand that maximum benefit will occur with consistent attendance and by my self, my child and/or my family putting effort forth throughout the process. Additionally, I understand that the therapy process can be uncomfortable and that I/we may feel conflicted about my/our therapy at points during treatment.

My signature below indicates that I have read and fully understand this Consent for Treatment form.

I _____ consent to allow Angela Sadowski, MSW, CSW-PIP, QMHP to provide therapy services to me, the above named client at an agreed upon rate of $0 per 50 minute session as my sessions are currently covered by my EAP plan. I understand that I will be billed the full session rate of $150 for any missed sessions or cancellations with less than 24 hours' notice (Excluding Mines & Associates EAP members).

_____ _____
Client Signature Date

_____ _____
Parent Signature Date

_____ _____
Angela Sadowski, MSW, CSW-PIP, QMHP Date

Angela Sadowski Counseling Services

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, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. 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 our 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 posting a copy on our website, 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

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. 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, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child or Elder Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public 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. 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.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Raab Counseling & Consulting Services PO Box 100814 Denver, CO 80250:

 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 is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are 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 cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

 Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

 Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. 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 use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

 Right to Request Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

 Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

 Right to a Copy of this Notice. You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Bethany Jones Raab, LCSW, at PO Box 100814 Denver, CO 80250 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013.

Angela Sadowski Counseling Services

Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Patient/Client Name:_____

DOB: _____

SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Angela Sadowski Counseling & Consulting Services' Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Angela Sadowski, CSW-PIP, at 605-251-4504.

_____

Signature of Patient/Client Date

_____

Signature or Parent, Guardian or Personal Representative □ Date

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Staff Member Date

Angela Sadowski

MSW, LCSW-PIP, QMHP
707 E. 41st Street
Sioux Falls, SD 57105
Phone: 605-251-4504

Telehealth Informed Consent

I, _____, hereby consent to engaging in telehealth at Angela Sadowski as part of my counseling therapy. I understand that telehealth includes the practice of health delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive 2-way audio, video, or data communications. I understand that, with my signed consent, telehealth may also involve the communication of my mental health information, both orally and visually, to other health care practitioners to ensure continued and effective care.

Technology

1. I understand that I will need to download an application and/or software to use this platform.
2. I also need to have broadband internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services.
3. I also understand that in case of technology failure, Angela Sadowski, will contact me via phone to coordinate alternative methods of treatment or reschedule.

Video/Audio Recording

1. As a general practice Angela Sadowski **DOES NOT** record telehealth sessions.
2. As a client, you agree **NOT** to record telehealth session.

Client Rights

1. I have the right to withdraw my consent at any time.
2. I understand that Angela Sadowski utilizes secure, encrypted audio/video transmission software to deliver telehealth.
3. I understand that telehealth services and care may not be as complete as face-to-face services.
4. I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.
5. I understand that I have a right to access my mental health information and copies of medical records in accordance with state and federal laws.
6. I give permission to Angela Sadowski to text/email/fax me the link for the online programs for this telehealth service.

I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Client signature: _____ Date: _____

Client guardian signature: _____ Date: _____

Provider's name and signature: _____ Date: _____