



Minor - Therapy

Welcome

New Patient Registration Procedure:

1. **Give office staff your insurance card and photo ID to copy.** (Or give it to your therapist to copy at the beginning of your session if office staff is not available.)
2. **Read the packet:** Read the enclosed Contracts and Disclosures Packet, including:
 - a. Hoover & Associates' Outpatient Services Agreement
 - b. Hoover & Associates' Financial Agreement
 - c. Hoover & Associates' Information about Privacy and Patient Rights

We apologize for the length of these documents; however, it is important that we make clear to you the policies and procedures of the office to assure that the decision you make, to consent to receive services, is made on the basis of all the facts. These documents contain important information about our professional services and policies. Please read them carefully and make note of any questions you might have, so that you can discuss them with your therapist. Once you sign the Agreement to Terms of Service, these documents will constitute a binding agreement between us.

3. **Fill out the front and back of the last page.**
 - a. Complete the Agreement to Terms of Service:
 - Initial next to the name of each document, acknowledging that you've received it, read it, understood it, and agree to it.
 - Then sign and date on appropriate signature lines as indicated.
 - b. Complete, sign and date the Registration Form that is on the back of the last page.
4. **Give the last page to office staff:** Separate the last page from the rest of the packet and give it to office staff. (Or give it to your therapist if office staff is not available.)
5. **Keep the rest of the packet.** (Also make sure you get your insurance card and ID back once they've been copied.)
6. **Payment:**
 - a. Please see the enclosed Financial Agreement for information about payment.
 - b. Payment should be made toward remaining deductible, co-pay, co-insurance, or balance at time of services, if known. These are often not known at the time of the first session.
 - c. If office staff is not available, you can make a payment directly to your therapist, or if you wish to be billed, please inform your therapist.
7. **If you have any questions** or concerns please discuss them with your therapist or office staff.



OUTPATIENT SERVICES AGREEMENT

A. PSYCHOLOGICAL SERVICES

1. **Psychotherapy and other psychological services are not easily described in general statements.** They vary depending on the personality of both the therapist and the patient, and the particular problems which the patient brings. They also vary depending on the age of the patient, or whether a child, a couple, or a whole family is being treated. There are a number of different approaches which can be utilized to address the problems you hope to work on. It is not like visiting a medical doctor, because psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work both during your sessions and at home.
2. **Psychotherapy has both benefits and risks.** For individual patients, the risks sometimes include experiencing uncomfortable levels of feelings such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness. Sometimes psychotherapy results in an increased level of conflict between the patient and significant others. Psychotherapy often requires recalling unpleasant aspects of your history. If a couple or family is being treated, an increased level of conflict can occur, and such an increase could lead to a decision to end a relationship. Psychotherapy has also been shown to have benefits for many people who undertake it. It often leads to a significant reduction of feelings of distress, to better relationships, and to resolutions of specific problems. However, there are no guarantees about what will happen.
3. By the end of the first session (sometimes it takes longer), your therapist will be able to offer you some initial impressions of what your work will include and an initial treatment plan, if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with your therapist. Therapy involves a large commitment of time, money and energy, so **you should be very careful about the therapist you select.** If you have questions about our procedures, concerns, or doubts about whether your therapist is the right one for you, you should discuss them whenever they arise. If any doubts persist, your therapist will be happy to help you secure an appropriate consultation with another mental health professional.

B. MEETINGS

1. An intake evaluation will be conducted at the beginning of treatment. Your therapist can discuss with you the length and number of intake sessions to expect. During this time, you and the therapist can decide whether your therapist is the best person to provide the services which you need in order to meet your treatment objectives. If psychotherapy is initiated, **your therapist will usually schedule one session per week.** Your therapist will discuss with you the length and frequency of sessions. Once this appointment time is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation or unless it is agreed that you were unable to attend due to circumstances which were beyond your control.
2. **The frequency of session will be reduced over time as appropriate,** and will be stopped when you and your therapist agree that you've met your goals. Our services are voluntary and can be stopped at any time at client request, although sometimes a third party may require treatment or evaluation for a specific reason, and may impose consequences if their requirements aren't met.

C. CONTACTING YOUR THERAPIST

1. **Telephone:** Your therapist is often not immediately available by telephone. You can leave a voicemail in our confidential voicemail system, you can talk with our receptionists about scheduling, or if needing urgent assistance, you can dial 1 for the answering service, who can page the clinician on call. If you are in crisis or dealing with an emergency, please call 911 or go to your nearest emergency room. We will make every effort to return your call by

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the end of the next business day, with the exception of weekends and holidays. If you are difficult to reach, please leave times when you are available. If you cannot reach your therapist, and you feel that you cannot wait for a return phone call, you should call your family physician, your psychiatrist, or the emergency room at the nearest hospital and ask for the psychiatrist on call. When your therapist is away on vacation or unavailable, the on-call psychologist will receive and return your call.

2. **Email:** Although you can contact your clinician by email or through the Hoover & Associates website, email is not a secure form of communication, and therefore you should not discuss sensitive matters or seek clinical advice through email. For more details, see Hoover & Associates' Information about Privacy and Patient Rights.
3. **Social Media and Digital Technology:** Social media is publicly visible, and therefore friending, following, or "liking" your therapist would expose your association with them, thereby breaching your privacy. For more details, see Hoover & Associates' Information about Privacy and Patient Rights.

D. **ENDORSEMENTS, TESTIMONIES, REVIEWS AND RATINGS**

Endorsing, reviewing or rating your therapist on a third-party directory or business review site would be publicly visible, and would be a breach of your privacy. Therefore **we strongly discourage patients from posting any reviews, testimonials, endorsements, or ratings.** For more details, see Hoover & Associates' Information about Privacy and Patient Rights.

E. **PROFESSIONAL RECORDS**

Both law and the standards of our profession require that we keep appropriate treatment records. Because these are professional records, they can be misinterpreted and/or can be upsetting. Therefore, if you ever request a copy of your records, it is important that you ask your clinician for clarification if you have any questions or concerns. For more information about the handling of your health records, please see Hoover & Associates' Information about Privacy and Patient Rights.

F. **CONFIDENTIALITY**

Please see Hoover & Associates' Information about Privacy and Patient Rights for information about confidentiality.

G. **PAYMENT AND INSURANCE REIMBURSEMENT**

Please see the Hoover & Associates' Financial Agreement for information regarding payment and insurance reimbursement.



FINANCIAL AGREEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for your treatment.

A. CLIENT RESPONSIBILITY FOR PAYMENT

1. **Adult patients** are legally responsible for the timely payment for services received from their psychotherapist(s) at Hoover & Associates. If using insurance, payments are due after claims have been processed by the insurance company. If paying cash, payments are due at the time of service.
2. The **parent/guardian** who brings a minor child in for treatment is responsible for the bill. In other words, they are responsible to pay the balance for the minor child they brought in for services, rather than expecting the other parent, or anyone else, to pay the balance. If using insurance, payments are due after claims have been processed by the insurance company. If paying cash, payments are due at the time of service.
3. If the patient is a **dependent adult**, another responsible party must guarantee payment, as in the case of a minor child.
4. The word “**client**” below refers to the party responsible for the payment.

B. PRICES / FEES

1. **Samples of Hoover & Associates’ full fees (before adjustment)** are listed on our session tickets. Clients may ask the receptionist or their therapist about prices for any services and session lengths.
2. **Missed appointment fees** are charged when appointments are missed with no cancellation call, and when appointments are cancelled less than 24 hours ahead of time. Missed appointment fees may be up to the full fee for the missed session. Clients can ask their therapist for further details about how the therapist usually handles this. **Insurance does not pay for missed appointment fees.**
3. **Phone sessions: Insurance does not pay for phone therapy.** Therefore any phone therapy, if provided, would be the client’s responsibility. Phone sessions cost \$35 for 5-10 minutes, \$70 for 11-20 minutes, and \$105 for 21-30 minutes.

C. PAYMENTS / INSURANCE ACCEPTED

1. **Payment Options:**
 - a. Payments can be made directly to the therapist, to business office staff, or by phone, or by mail.
 - b. Hoover & Associates accepts cash, checks, money orders, and debit or credit cards, including: Visa, MasterCard, Discover, and American Express. Automatic payments can be arranged when using a credit card.
 - c. Hoover & Associates accepts insurance reimbursement as follows:
 - Most Hoover & Associates clinicians are in-network with Blue Cross Blue Shield PPO and Aetna PPO. Some are also in-network with Cigna PPO, Medicare, Southland IPA, and Comppsych. (see D1 below)
 - We can accept reimbursement from other insurance companies as well, at out of network rates (see D2 below).
 - d. Some therapists also accept **sliding scale fees** through the **Family Education Center**.
2. Please see the **clinicians’ website profiles** for more information about the forms of payment each one accepts, and insurance companies with which each is paneled.
3. **Timely Payments:** Clients make payments on the date of service (once amount of co-pay is known), or within 30 days of receiving a bill from Hoover & Associates, unless special arrangements have been made (see section G below).

D. **IF USING INSURANCE**

1. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will provide you with whatever assistance we can in facilitating your receipt of the benefits to which you are entitled, including filling out forms and filing claims as appropriate. However, you, not your insurance company, are responsible for payment of the fee we have agreed to. Therefore, **it is very important that you find out exactly what mental health services your insurance policy covers.** You should carefully read the section in your insurance coverage booklet which describes mental health services. If you have questions, you should call your insurance company and inquire about your coverage.
2. Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available, and what will happen if the insurance benefits run out before you feel ready to end sessions with your therapist. **It is important to remember that you always have the right to pay for services yourself and avoid complexities involved with insurance.**
3. Recent changes in laws related to healthcare and insurance have resulted in an increasing level of confusion about insurance benefits, which sometimes makes it difficult to determine exactly how much coverage is available. **If you have any question about your coverage, we will do our best to help you get answers.**
4. **You should also be aware that most insurance agreements require you to authorize us to provide them with a clinical diagnosis, and sometimes additional clinical information** such as a treatment plan or summary, or in rare cases, a copy of the entire record. This information will become part of the insurance company's files, and, in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, we have no control over what they do with it. In some cases *they* may share the information with a national medical information data bank. If you request it, we will provide you with a copy of any report which we submit.
5. **In Network:** The client's insurance company sets a "usual and customary" dollar amount which they allow in-network providers (therapists) to receive for each type of service.
 - a. Insurance then pays a certain percentage of that "usual and customary" amount (depending on the policy), and the client pays the remaining percentage "coinsurance". Or the insurance company sets a "copay" which is not a percentage but a dollar amount (such as \$25 per session).
 - b. Hoover & Associates adjusts their fees down to the "usual and customary" amount set by insurance companies with whom we are "in network". This is reflected on statements as an "**adjustment.**"
 - c. The "usual and customary" rates allowed by the insurance company are subject to change and are not guaranteed until the claim is processed. Therefore it is impossible to guarantee the exact price of each session (or the exact amount of the coinsurance) until after the insurance has processed the first couple of sessions.
 - d. The client can wait until their insurance company has processed their claim before they start paying coinsurance (if any).
 - e. Clients are required to pay their copay (if any) at the time of each visit.
6. **Out of Network:** If the client's therapist is out of their insurance company's network, then:
 - a. The client is responsible to pay the difference between the session fee and the amount their insurance pays.
 - b. The insurance policy determines the client's "out of network" coverage, which may be less than their coverage if they had chosen an "in-network" therapist.
7. The client pays the portion they owe (their **copay, coinsurance, and/or deductible**) either on the date of service (if amount is known) or when billed by Hoover & Associates.
8. **The client is responsible for the timely payment of any services received and not covered by their insurance,** as allowed by contractual agreement or law. This includes missed appointment fees and phone therapy fees.
9. Hoover & Associates strongly recommends that the client confirm their benefits before treatment to avoid difficulties. **It is the client's responsibility to know their insurance plan,** including, but not limited to:
 - a. Whether their policy covers outpatient mental health services.
 - b. Whether their policy requires pre-authorization and re-authorization.
 - c. Whether they have to pay a yearly deductible, and how much they currently owe on it.
 - d. What percentage of the "usual and customary charge" their insurance will cover, and what percentage they have to pay (their coinsurance/co-pay).
 - e. Whether their insurance policy has a limit on the number of outpatient mental health sessions per year (or per lifetime), and whether they're close to it.
 - f. Whether their insurance policy has a limit on the dollar amount paid out annually (or over a lifetime), and whether they're close to it.
10. **If the client needs help understanding their insurance plan,** they can discuss this with their therapist or with the business office staff at Hoover & Associates. We're happy to help.
11. Hoover & Associates files insurance claims on a daily basis. **If the client chooses to file their own insurance claim,** they must pay in full at each session, and they must request that a diagnosis be indicated on their receipt.

12. A **diagnosis** will be required by the insurance company, and some diagnoses are not covered by insurance, resulting in claim denial. The client has a right to discuss their (or their dependant's) diagnosis with the treating professional.
13. Hoover & Associates uses "**remainder statements**" showing only the amount due after insurance has paid. Therefore bills will not show previously paid charges or charges still pending with insurance.

E. **IF NOT USING INSURANCE:** If the client is paying directly for services received at Hoover & Associates, payment in full is due at the time of each service.

F. **SPECIAL ARRANGEMENTS:**

1. If the client is struggling to pay their bill, it is their responsibility to discuss this with their psychotherapist. If appropriate, a written and signed individualized **payment plan** or **special fee agreement** may be designed. Individualized payment plans and special fee agreements are granted only under special circumstances and are at the discretion of the psychotherapist.
2. A therapist may choose to require special conditions with regards to billing and payment for a particular client, in circumstances which warrant it, such as a history of failure to pay in a timely manner.

G. **FAILURE TO PAY:**

1. Hoover & Associates will add a **1% interest charge** on balances that are over 60 days past due.
2. There will be a \$25 fee for any **returned checks**.
3. If bills sent by Hoover & Associates are not paid by the 3rd bill (after 90 days), the client's outstanding bill may be sent to **collections**. If this happens, the client is responsible for any collection fees and any other costs associated with the collections process. Once an account has been listed with the collection agency, payments must be made directly to the collection agency. Our office cannot accept collection payments.
4. A therapist may decline further services to clients who have a history of failure to pay.

Questions regarding insurance or billing can be left on the voicemail of **Carrie in the business office at (708) 429-6999, extension 228**. Please note that the business office is not staffed by full time employees. Although we try to return calls within one business day, returning a call may sometimes take two to three business days. For an urgent business matter, please contact your treating psychotherapist.



INFORMATION ABOUT PRIVACY AND PATIENT RIGHTS

This is a notice of Hoover and Associates' and your clinician's policies and practices to protect the privacy of your health information. THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Please talk with your therapist if you have any questions or concerns about this policy.

A. USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, **here are some definitions:**

1. **“PHI”** refers to information in your health record that could identify you.
2. **“Treatment”** is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when your clinician consults with another health care provider, such as your family physician or another clinician.
3. **“Payment”** is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care, or to determine eligibility or coverage. If your insurance is provided via a managed care plan, you probably have already signed a release form allowing your therapist to communicate with the case manager.
4. **“Health Care Operations”** are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
5. **“Use”** applies only to activities within our practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
6. **“Disclosure”** applies to activities outside of our practice group, such as releasing, transferring, or providing access to information about you to other parties.
7. **“Authorization”** is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

B. USES AND DISCLOSURES REQUIRING AUTHORIZATION

1. We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when we are asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. There will be a charge for any preparation time which is required to comply with an information request (with the exception of routine communication with the managed care representative or collateral service providers).
2. We would also need to obtain an additional and specific authorization before releasing your Psychotherapy Notes. “Psychotherapy Notes” are notes your clinician makes about your conversations during a private, group, joint, or family counseling session, which we keep separate from the rest of your record. These notes are given a greater degree of protection than PHI.
3. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.
4. We will also obtain an authorization from you before using or disclosing PHI in any ways that are not described in this Notice.

C. **USES AND DISCLOSED WITHOUT AUTHORIZATION**

In general, the confidentiality of all communications between a client and a psychologist is protected by law, and your therapist can only release information to others with your written permission. However, there are a number of exceptions. We may use or disclose PHI without your consent or authorization in the following circumstances:

1. **Consultation:** Your therapist may occasionally find it helpful to consult about a case with other professionals. In these consultations, the identity of clients is not revealed. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, your therapist will not tell you about these consultations unless he/she feels that it is important to your work together.
2. **Risk of Harm**

There are some situations in which your therapist is legally required to take action to protect you or others from harm, even though that may require revealing some information about your treatment.

 - a. **Serious Threat to Your Own Health or Safety:** If we believe that you present an imminent, serious risk of physical or mental injury or death to yourself, we may make disclosures we consider necessary to protect you from harm. Additionally, we are required to make a report to the State of Illinois through the FOID reporting system relating to the “concealed carrying” of firearms.
 - b. **Serious Threat to the Health or Safety of Others:** If you communicate to us a specific threat of imminent harm against another individual, or if we believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, we are required to take protective actions, which may include making disclosures that we believe are necessary to protect that individual from harm, such as notifying the potential victim, notifying the police, contacting family members or others who can help provide protection, and/or seeking appropriate hospitalization for the client. Additionally, we are required to make a report to the State of Illinois through the FOID reporting system relating to the “concealed carrying” of firearms.
 - c. **Ongoing Abuse, Neglect or Financial Exploitation of a Child, Elderly Person, or Disabled Person:** If we have reasonable cause to believe that an individual (who is protected by state law), known to us in our professional capacity, may be abused or neglected, we must file a report with the appropriate state agency. Furthermore, if you report an ongoing case of abuse, neglect or exploitation to us (even if the victim is not in our professional care), we may file a report with the appropriate state agency, depending on the details and evidence you report.
 - d. **The determination that you are “Intellectually Disabled” or “Developmentally Disabled.”** We are required to make a report to the State of Illinois through the FOID reporting system relating to the “concealed carrying” of firearms if you are determined to be intellectually or developmentally disabled.
 - e. **These situations rarely arise.** Should such a situation occur, your therapist will make every effort to discuss it with you, and do his/her best to resolve any concerns you have about the actions taken.
3. **Health Oversight Activities** - We may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions.
4. **Judicial and Administrative Proceedings** - If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and we must not release such information without a court order. We can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or when the evaluation is court ordered. You must be informed in advance if this is the case. In most judicial proceedings, you have the right to prevent your therapist from providing any information about your treatment. However, in some circumstances, such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require your therapist’s testimony if he/she determines that resolution of the issues before him/her demands it.
5. **Worker's Compensation** - We may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
6. When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state’s confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security or intelligence.
7. While this written summary of exceptions of confidentiality should prove helpful in informing you about potential problems, it is important that any questions or concerns you may have are discussed with your therapist. As you might suspect, the laws governing these issues are quite complex. While your therapist is happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable. At your request, your therapist will provide you with relevant portions of the applicable state laws governing these issues.

D. **MINORS**

You and your therapist will discuss confidentiality and how much involvement/information your parents will have concerning your treatment.

E. **ELECTRONIC COMMUNICATION**

4. **Email:** Although you can contact your clinician by email or through the Hoover & Associates website, email is not a secure form of communication, and therefore *you should not discuss sensitive matters or seek clinical advice through email*. Instead, you should limit email to information such as inquiring about services, to answer general questions about the practice (such as about payment, scheduling, or clinician specialties) or for scheduling. Please use the telephone or face-to-face communication for sensitive matters. Additionally, *email should never be used in emergency situations*. If you are in an emergency, you should call 911 or go to your nearest emergency room. If you choose to communicate with Hoover & Associates by email, the confidentiality of any emailed information cannot be assured. If you send Hoover & Associates an email, ask for a response from Hoover & Associates, and provide your email address; you are granting your consent for Hoover & Associates to respond to you by email, unless you request that a response be made by another means that you specify in your e-mail message.
5. **Social Media and Digital Technology:** If your clinician uses social media or other related digital technology, their private accounts will be separate and isolated from any used for professional counseling purposes, including those used with prospective or current clients. Please keep in mind that social media is publicly visible, and therefore friending, following, or “liking” your therapist would expose your association with them, thereby breaching your privacy (others may infer that you’ve received mental health services). Therefore many clinicians do not accept friend requests from their clients. Clinicians also will not use social media to discuss confidential information.
6. **Endorsements, Testimonies, Reviews, and Ratings:** Endorsing, reviewing or rating your therapist on a third-party directory or business review site would be publicly visible, and would be a breach of your privacy. Therefore *we strongly discourage patients from posting any reviews, testimonies, endorsements, or ratings*. If you find a listing for your therapist, know that it is *not* a request for a testimonial, rating, or other endorsement from you as their client. Due to confidentiality, we cannot respond to any reviews on any sites whether they are positive or negative. We encourage you to take your own privacy as seriously as we take our commitment to maintain your confidentiality (don’t state anything personal about yourself – your privacy cannot be ensured on those sites). If you state anything on these sites, there is a good possibility that your therapist may never see it.

F. **PATIENTS’ RIGHTS**

1. **Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket.** You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for our services.
2. **Right to Request Other Restrictions** - You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
3. **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a therapist. On your request, we will send your bills to another address.)
4. **Right to Inspect and Copy** - You have the right to inspect or obtain a copy (or both) of PHI in your mental health and billing records used to make decisions about you, for as long as the PHI is maintained in the record and Psychotherapy Notes. On your request, we will discuss with you the details of the access process.
5. **Right to Amend** - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
6. **Right to an Accounting** - You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.
7. **Right to a Paper Copy** - You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to receive the notice electronically.
8. **Right to Be Notified if There is a Breach of Your Unsecured PHI.** You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to governmental standards; and (c) our risk assessment fails to determine that there is a low probability that your PHI has been compromised.

G. CLINICIANS' DUTIES

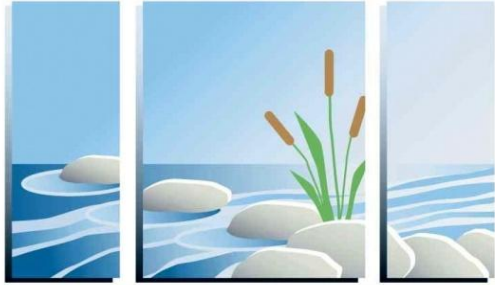
1. We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
2. We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
3. If we revise our policies and procedures, we will provide you with written notice at the time of service, or by mail in response to any inquiry.
4. In the event of your therapist's unexpected death or incapacitation, your records will be accessible to and through the Clinical Director of Hoover & Associates, or other Hoover & Associates staff designated by the Clinical Director (their designee), who is also familiar with the ethical or legal requirements regarding PHI. The confidentiality of your records will continue to be maintained in the same ways as outlined above. Furthermore, the Clinical Director (or their designee) will assist you in locating other professional mental health providers as well as ensure proper transfer of client records.

H. COMPLAINTS

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about access to your records, you may contact Marlin C. Hoover, Ph.D., M.S. at 708-429-6999. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

I. RESTRICTIONS AND CHANGES TO PRIVACY POLICY

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will make future revisions of this policy easily available to existing patients, by putting a notice in reception and on our website informing you of updates. You can also request a copy of updated policies from your therapist.



HOOVER & ASSOCIATES

Minor - Therapy AGREEMENT TO TERMS OF SERVICE

Please *initial* next to each document name, and sign below, to indicate that you have received, read, understood, and that you agree to the terms of service specified in each of the documents listed below:

Guardian: _____ Patient age 12 or older: _____ Hoover & Associates' Outpatient Services Agreement

Guardian: _____ Patient age 12 or older: _____ Hoover & Associates' Financial Agreement

Guardian: _____ Patient age 12 or older: _____ Hoover & Associates' Information about Privacy and Patient Rights

Guardian Consent for Treatment of a Minor:

I hereby give consent for _____
Name of Minor (please print)

Date of Birth (MM/DD/YY)

to receive psychological services.

Parent or Guardian and Financially Responsible Party Name (please print)

Relationship to Patient

Parent or Guardian Signature

Date

Second Parent or Guardian Name (please print) (if applicable)

Relationship to Patient

Second Parent or Guardian Signature (if applicable)

Date

Patient Age 12 or Older

Patient Age 12 or Older Signature

Date

Witness:

Witness Name (please print)

Witness Signature (signed in the presence of)

Date

**Hoover & Associates
MINOR REGISTRATION FORM**

Patient Name: _____ **Date of Birth:** (MM/DD/YY) _____

Age: _____ **Grade:** _____ **School:** _____

Primary Address for Billing and Communications _____

Contact 1: Name: _____ Check one: ()mother ()father ()guardian

Cell phone: _____ Home phone: _____

Work phone: _____ Email: _____

Preferred method of contact: ()cell phone ()home phone ()work phone ()email

Contact 2: Name: _____ Check one: ()mother ()father ()guardian

Cell phone: _____ Home phone: _____

Work phone: _____ Email: _____

Preferred method of contact: ()cell phone ()home phone ()work phone ()email

Referred by: ()professional ()family/friend ()internet ()other: _____

If referred by a professional, please specify:

()primary doctor ()psychiatrist ()therapist ()other professional _____

Name of referring professional: _____

Referring professional's practice or organization: _____

Referring professional's phone number: _____

Referring professional's address: _____

What are the chief concerns for which you would like services? _____

Has this patient received other mental health services in the past? Y N If yes, was it at Hoover & Associates? Y N

Name of person completing this form (and financially responsible party): _____

Relationship to the child: _____

Signature: _____ **Date:** _____

| |
|---|
| FOR OFFICE USE ONLY: DX CODE: _____ CLINICIAN INITIALS: _____ |
|---|