

# JANIS B. RICE, M.A., L.P.C.

17049 El Camino Real #208  
Houston, Texas 77058  
(281) 538-8008

## Notice of Privacy Practices (NPP)

**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**

Privacy is a very important concern for many clients. Privacy is also a complicated issue because of the many federal, state, and local laws and rules of professional ethics. Because the laws and rules are so complicated, some parts of this **Notice of Privacy Practices (NPP)** are very detailed and you may have to read them several times to understand them, and since I don't want to make you read a lot that may not apply to you, some items that occur infrequently have been omitted. If you have any questions or want to know more about anything related to privacy, please ask me for more explanations or details.

### **Privacy and the Laws**

I am also required to tell you about privacy because of the privacy regulations of a federal law, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**. The HIPAA law requires me to keep your medical information private and to give you this Notice that describes my legal duties and privacy practices. I will obey the rules of this NPP as long as it is in effect, but if I change it the new NPP will apply to all the medical information I keep. You can get a copy of the current NPP from my office, by telephone request at (281) 538-8008, or by mailing a request to me at 2951 Marina Bay Drive #130-114, League City, TX 77573.

### **What I Mean by your Medical Information**

Each time you visit me or any doctor's office, hospital, clinic, or other "healthcare provider", information is collected about you and your physical and mental health. It may be information about your past, present, or future health or conditions, or the tests and treatment you received, or about payment for healthcare. The information I collect from you is known as **Protected Health Information (PHI)** and goes into your **medical or healthcare record**.

In my practice, records are likely to include these kinds of information:

- Your history - as a child, in school and at work, marriage and personal history
- Reasons you came for treatment - problems, complaints, symptoms, or needs
- Diagnoses - the medical terms for your problems or symptoms
- Treatment plan - a list of treatments and other services which I think might help you
- Progress notes - each time you come in, I write down some things about how you are doing, what I notice about you, and what you tell me
- Records I get from others who treated you or evaluated you
- Psychological test scores, school records, and other such reports
- Information about medications you took or are taking
- Legal matters
- Billing and insurance information

I use this information for many purposes. For example, I may use it:

- To plan your care and treatment
- To decide how well treatments are working for you
- When I talk with other health care professionals who are also treating you, such as your family doctor or other professional who might have referred you to me
- To show that you actually received services from me which I billed to you or to your health insurance company
- For teaching and training other healthcare professionals
- For medical and psychological research
- For public health officials trying to improve health care
- To improve the way I do my job by measuring the results of my work

These lists are just examples of what kind of information is contained in your records and how it is used, and there may be other kinds of information and uses for your records. When you understand what is in your records and what it is used for, you can make better decisions about who, when, and why others should have this information.

Although your medical or healthcare records are the physical property of the healthcare practitioner or facility that collected it, the information belongs to you. You can read it and if you want a copy we can make one for you (but may charge you for any related copying and mailing costs). In some situations you cannot see all of what is in your records. If you find anything in your records that you think is incorrect or believe that something important is missing, you may ask me to make some kinds of changes (called amending) to your health information. You may have to make this request in writing. You must tell me the reasons you want me to make the changes, although in some cases I do not have to agree to do so.

### **How your Protected Health Information (PHI) can be Used and Shared**

When your information is read by me or others that is called, in the law, "**use**". If the information is shared with or sent to others outside my office, that is called, in the law, "**disclosure**". Except in some special circumstances, when I use your PHI or disclose it to others I share only the minimum necessary PHI needed for those other people to do their jobs. The law gives you rights to know about your PHI, how it is used, and to have a say in how it is disclosed (shared) and so I will tell you more about what I do with your information.

I use and disclose PHI within my practice for several reasons. Mainly, I will use and disclose it for routine purposes and I will explain more about those below. For other uses or disclosures outside of my practice, I must tell you about them and have a written **Authorization Form** unless the law lets or requires me to make the disclosure without your authorization. However, the law also says there are some uses and disclosures that don't need your consent or authorization.

#### **1. Uses and Disclosures of PHI in Healthcare *with your consent***

After you have read this Notice, you will be asked to sign a separate **Consent Form** to allow me to use and share your PHI within my practice. In almost all cases, I intend to use your PHI or share your PHI with other people or organizations to provide **treatment** to you, arrange for **payment** for my services, or some other business functions called health care **operations**. Together, these routine purposes are called **TPO** and the Consent Form allows me to use and disclose your PHI for TPO. Take a minute to re-read that last sentence until it is clear because it is very important. Next, I will tell you more about TPO,

##### **1a. For Treatment, Payment, or Health Care Operations**

I need information about you and your condition to provide care to you. You have to agree to let me collect that information and to use it and share it to care for you properly. Therefore you must sign the Consent Form before I can begin to treat you because if you do not agree and consent I cannot treat you.

When you come to see me, the information that is collected about you may go into your healthcare records. Generally, I may use or disclose your PHI for three purposes: treatment, obtaining payment, and what are called healthcare operations. Each of these three uses are discussed in the next few paragraphs.

### ***For Treatment***

I use your medical information to provide you with psychological treatments or services. These might include individual, family, or group therapy, psychological, educational, or vocational testing, treatment planning, or measuring the benefits of the services I provide.

I may share or disclose your PHI to others who provide treatment to you. I am likely to share your information with your personal physician. If you are being treated by a team, they can share some of your PHI among themselves so that the services you receive will work together. The other professionals treating you will also enter their findings, the actions they took, and their plans into your medical records so we all can decide what treatments work best for you and make up a **Treatment Plan**. I may refer you to other professionals for services I cannot provide. When and if I do this, I will need to tell them some things about you and your conditions. I will get back their findings and opinions and those will go into your records. If you receive treatment in the future from other professionals, I can also share your PHI with them. These are some of the examples so that you can see how I might use and disclose your PHI for treatment.

### ***For Payment***

I may use your information to bill you, your insurance, or others so I can be paid for the treatments I provide to you. I or a business associate may contact your insurance company to check on exactly what your insurance covers. I may have to tell them about your diagnoses, what treatments you have received, and the changes I expect in your conditions. I will need to tell them about when we met, your progress, and other similar things.

### ***For Health Care Operations***

There are a few other ways I may use or disclose your PHI for what are called health care operations. For example, I may use your PHI to see where I can make improvements in the care and services I provide. I may be required to supply some information to some government health agencies so they can study disorders and treatments and make some plans for services that are needed. If I do, your name and personal information will be removed from what I send.

## **1b. Other Uses in Healthcare**

***Appointment Reminders:*** I may use and disclose medical information to reschedule or remind you of appointments for treatment or other care. If you want me to call or write to you only at your home or your work or prefer some other way to reach you, I usually can arrange that if you let me know.

***Treatment Alternatives:*** I may use and disclose your PHI to tell you about or recommend possible treatments or alternatives that may be of help to you.

***Other Benefits and Services:*** I may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

***Research:*** I may use or share your information to do research to improve treatments. For example, comparing two treatments for the same disorder to see which seems to work better or faster or costs less. In all cases your name, address and other personal information will be removed from the information given to researchers. If they need to know who you are, I will discuss the research project with you and you will have to sign a special Authorization Form before any information will be shared.

***Business Associates:*** There may be some other businesses or individuals who do work for me. In the law, they are called Business Associates. An example might be billing or accounting services that prepare and mail my bills and update my financial records. These business associates need a limited amount of your PHI to do their jobs properly. To protect your privacy they have agreed in their contracts with me to safeguard your information.

## **2. Uses and Disclosures that Require your Authorization**

If I want to use your information for any purpose besides for TPO and the types of things described above, I need your permission on an Authorization Form. I don't expect to need this very often.

If you do authorize me to use or disclose your PHI, you can revoke (cancel) that permission, in writing, at any time. After that time I will not use or disclose your information for the purposes that you agreed to. Of course, I cannot take back information I had already disclosed with your permission or already used.

### **3. Uses and Disclosures of PHI from Mental Health Records that *do not* require a Consent or Authorization**

The law lets or makes me use and disclose some of your PHI without your consent or authorization in some cases. Here are some examples of when we might have to share your information.

#### ***When required by law***

There are some federal, state, or local laws which require me to disclose PHI:

- I have to report suspected child abuse
- If you are involved in a lawsuit or legal proceeding and I receive a subpoena, discovery request, or other lawful process, I may have to release some of your PHI. I will only do so after trying to tell you about the request, consulting with your lawyer, or trying to get a court order to protect the information they requested.
- I have to disclose some information to government agencies which check on me to see that I am obeying the privacy laws.

#### ***For law enforcement purposes***

I may release medical information if asked to do so by a law enforcement official to investigate a crime or criminal.

#### ***For specific government functions***

I may disclose PHI of military personnel and veterans to government programs relating to eligibility and enrollment. I may also disclose your PHI to Workers Compensation and Disability programs, or for national security reasons.

#### ***To prevent a serious threat to health or safety***

If I come to believe that there is a serious threat to your health or safety or that of another person or the public, I can disclose some of your PHI. I will only do this to persons who can prevent the danger.

### **4. Uses and Disclosures where you have an Opportunity to Object**

I can share some information about you with your family or close others. I will only share information with those involved in your care and anyone else you choose such as close friends or clergy. I will ask you about who you want me to tell what information about your condition or treatment. You can tell me what you want and I will honor your wishes as long as it is not against the law.

If it is an emergency - where I cannot ask if you disagree - I can share information if I believe that it is what you would have wanted or if I believe it will help you if I do share it. If I do share information, in an emergency, I will tell you as soon as I can. If you don't approve I will stop, as long as it is not against the law.

### **5. An Accounting of Disclosures**

When I disclose your PHI, I may keep some records of whom I sent it to, when I sent it, and what I sent. You can get an accounting (a list) of many of those disclosures.

#### **If you have Questions or Problems**

If you need more information or have questions about the privacy practices described in this notice, if you have a concern with how your PHI has been handled, or if you believe your privacy rights have been violated, please discuss it with me. You can talk with me about any of these issues in my office, or contact me by telephone at (281) 538-8008 or mail at: 2951 Marina Bay Drive #130-114, League City, TX 77573.

You have the right to file a complaint with me or with the U.S. Department of Health and Human Services, 200 Independence Avenue SW, Washington, DC 20201. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way.

The effective date of this notice is April 14, 2003.

**JANIS B. RICE, M.A., L.P.C.**

**17049 El Camino Real #208  
Houston, Texas 77058  
(281) 538-8008**

**OFFICE POLICIES AND PROCEDURES**

**PRACTICE:** This is an independent private therapy suite. On some occasions, office space may be shared with other mental health practitioners; however, each clinician maintains an independent private practice.

**OFFICE HOURS:** My normal office hours are weekdays 9:00 AM through 7:00 PM. All sessions must be scheduled by appointment. It may be possible to schedule sessions outside those hours by special arrangement.

**APPOINTMENTS:** Appointments are scheduled directly with me and are approximately **45** minutes long. If the need arises to reschedule or cancel your appointment, please call me at **(281) 538-8008** as soon as possible. If you arrive late for your appointment, your session time cannot be extended.

**CANCELLATION POLICY:** When you schedule an appointment, I consider that a commitment for you and me to work together to pursue your therapy goals. I am unable to help anyone else during that time. Sometimes emergencies arise, but whenever possible, try to put your health ahead of life's daily interruptions and keep your appointment.

If I need to cancel or change an appointment, I will give you 24 hours notice, as I know you have reserved time for your appointment. **If for any reason I cannot give you 24 hours notice, I will provide our next session at no cost to you.**

Likewise, I expect you to give me 24 hours notice if you must cancel an appointment. **Your insurance company will not pay for missed appointments.** If, for any reason, you cannot let me know 24 hours in advance, or forget your appointment, you will be charged my full fee of **\$100** as a missed appointment fee for the time you reserved.

ACKNOWLEDGEMENT INITIALS \_\_\_\_\_

**EMERGENCIES:** My main business telephone number is **(281) 538-8008**. I am usually in my office weekdays during scheduled appointments. If I am in session with a client, I can not be interrupted and will not be available to take your phone calls. However, I do check my voice mail frequently, and am automatically notified when I have messages. On other days, including week-ends or if I am out of town, I check for messages daily.

If you cannot reach me by phone but need to talk to someone urgently, you may wish to call Crisis Intervention of Houston, Inc. at **(713) HOTLINE OR (713) 468-5463**.

If you are in crisis or have a life-threatening emergency, call **911** or go to your nearest emergency room immediately.

ACKNOWLEDGEMENT INITIALS \_\_\_\_\_

Please Continue on Next Page

**OFFICE POLICIES AND PROCEDURES**  
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**FEES AND PAYMENT POLICY:** If I am a provider for your insurance company or Employee Assistance Program (EAP), I will be pleased to accept your insurance and file your claims for you, in which case you authorize payment be made directly to me. Your plan may require diagnostic and treatment plan information to be released to them before they will authorize payment. If you request that I accept your insurance or EAP benefits, I am obligated to comply with their requests for information.

If your insurance company or EAP happens to be one with which I am not contracted, known as “out-of-network”, I will provide receipts so you can submit claims to them. Please understand that you may or may not receive reimbursement.

If you do not have insurance or EAP coverage, or if you decide not to use those benefits, the initial evaluation and assessment session is **\$125**, and each follow-up session is **\$100**, payable when services are rendered. Under limited circumstances, special payment arrangements may be available.

Payment for services may be made in cash, by personal check, or major credit card. There is a **\$25** service charge for returned checks.

Insurance deductibles, co-payments, and co-insurance are your responsibility as is any balance of your account if your insurance company denies payment for any reason -- **you are ultimately responsible for payment of your account regardless of your insurance status**. I reserve the right to pursue collection of unpaid amounts using the services of a collection agency.

ACKNOWLEDGEMENT INITIALS \_\_\_\_\_

**CONFIDENTIALITY:** You have a legal and professional right to confidentiality of what we discuss in our sessions, and even to the fact that you are in therapy with me. I am required by federal law to safeguard that confidentiality. Except in certain situations, information will not be released to anyone without your written authorization. The major exceptions to confidentiality are issues involving child or elder abuse or neglect, threatened harm to self or others, mandated court orders, requests by parent(s) of minor client(s), and third party insurance information requirements. This information is explained in further detail in my **Notice of Privacy Practices (NPP)** which you hereby acknowledge that you have been provided.

ACKNOWLEDGEMENT INITIALS \_\_\_\_\_

I confirm that my therapist has discussed the above information with me. My signature below indicates my understanding of, and my agreement to accept, these policies and procedures.

\_\_\_\_\_  
Client or Client Representative Signature                      Initials                      Date

**JANIS B. RICE, M.A., L.P.C.**

17049 El Camino Real #208  
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**CLIENT INFORMATION FORM**

TODAY'S DATE: \_\_\_\_\_

**CLIENT:**

NAME: \_\_\_\_\_ SS#: \_\_\_\_\_

SEX \_\_\_ BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_

If Minor, PARENT(S)/GUARDIAN(S): \_\_\_\_\_

**ADDRESS:**

STREET: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**PHONES / EMAIL:**

(Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

(Work) \_\_\_\_\_ (OK to Call at Work?) (Leave Voice Messages OK?)  
YES / NO YES / NO

(Email) \_\_\_\_\_ (OK to Email?)  
YES / NO

Want appointment reminder? YES / NO - If YES (circle): by Phone: (Home) (Cell) (Work) or (Email)

**CLIENT'S**

**EMPLOYER/**

SCHOOL: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_ HIGHEST LEVEL EDUCATION \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ PHONE: \_\_\_\_\_

PRIMARY INSURED:

NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

INSURED'S

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

INSURANCE ID#: \_\_\_\_\_ SS#: \_\_\_\_\_

**SPOUSE/PARTNER:**

NAME: \_\_\_\_\_

RELATIONSHIP STATUS: ( ) Single ( ) Married (years) \_\_\_\_\_ ( ) Separated ( ) Divorced ( ) Widowed

**EMERGENCY CONTACT:** \_\_\_\_\_ PHONE: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

**FAMILY INFORMATION:** List everyone living with Client: (Spouse, Children, Parents, Relatives, Others)

NAME	AGE	RELATIONSHIP	NAME	AGE	RELATIONSHIP
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL INFORMATION:**

Primary Care Physician: \_\_\_\_\_ PHONE: \_\_\_\_\_

Other Physicians Treating You: \_\_\_\_\_ PHONE: \_\_\_\_\_

Current Medications: \_\_\_\_\_

**JANIS B. RICE, M.A., L.P.C.**

**17049 El Camino Real #208  
Houston, Texas 77058  
(281) 538-8008**

**Consent to Use and Disclose Your Health Information**

This form is an agreement between you, \_\_\_\_\_ and me, Janis B. Rice, M.A., L.P.C. When I use the word "you" below, it can mean you, your child, a relative, or another person if you have written his or her name here \_\_\_\_\_.

When I examine, test, diagnose, treat, or refer you, I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information to decide on what treatment is best for you and to provide any treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to let me use your information and send it to others. The Notice of Privacy Practices (NPP) explains in more detail your rights and how I can use and share your information. Please read the NPP before you sign this Consent form.

**If you do not sign this Consent form agreeing to what is in my Notice of Privacy Practices, I cannot treat you.**

In the future, I may change how I use and share your information and may change my Notice of Privacy Practices, which you hereby acknowledge you have been provided. If I do change it, you can get a current copy from my office, by contacting me by telephone at (281) 538-8008, or by mailing a request to: 2951 Marina Bay Drive #130-114, League City, TX 77573.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to those limitations. However, if I do agree, I promise to do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter to me at the above mailing address telling me you no longer consent) and I will comply with your wishes about not using or sharing your information from that time on but I may have already used or shared some of your information and cannot change that.

\_\_\_\_\_  
Signature of client or his or her personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client or personal representative

\_\_\_\_\_  
Relationship to client

\_\_\_\_\_  
Description of personal representative's authority

\_\_\_\_\_  
Janis B. Rice, M.A., L.P.C.

**JANIS B. RICE, M.A., L.P.C.**

**17049 El Camino Real #208  
Houston, Texas 77058  
(281) 538-8008**

**Authorization to Use and Disclose Protected Health Information (PHI)**

1. I am completing this form to allow use and sharing of protected health information about:

Printed name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

2. I authorize Janis B. Rice, M.A., L.P.C.

3a. To use or disclose the following information:

- Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness
- Admission and discharge summaries
- Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents
- Treatment, recovery, rehabilitation, aftercare plans and other similar plans
- Social, family, educational, and vocational histories
- Social work assessments, occupational therapy and vocational reports and evaluations
- Progress, Nursing, Case or similar notes
- Evaluations and reports of consultants
- Information about how the patient's condition(s) affects or has affected his or her ability to work, and to complete tasks or activities of daily living
- Billing records
- Academic and educational records, including achievement and other tests' results, reports of teachers' observations, and all other school or special education documents
- HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here  Do not release
- Complete copy of the medical record and folder in which it was kept
- Other: \_\_\_\_\_

3b. Dates of care included: From \_\_\_\_\_ to \_\_\_\_\_ and  
From \_\_\_\_\_ to \_\_\_\_\_ and From \_\_\_\_\_ to \_\_\_\_\_

4. With this person or organization: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. The information will be used/disclosed for the following purpose: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. I understand and agree that this Authorization will be valid and in effect until \_\_\_\_\_ [Enter a date or event upon which this Authorization expires]. I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.
7. I understand that I can revoke or cancel this Authorization at any time by sending a letter to you. If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that some information may have been sent or shared before that date.
8. I understand that I do not have to sign this Authorization and that my refusal to sign will not affect my abilities to obtain treatment from Janis B. Rice, M.A., L.P.C., nor will it affect my eligibility for benefits.
9. I understand that I may inspect and have a copy of the health information described in this Authorization. There may be a cost for those copies or other related services.  
 Does not apply
10. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be further disclosed to others and no longer protected by those regulations.
11. I understand that Janis B. Rice, M.A., L.P.C. will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it.  Does not apply
12. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

\_\_\_\_\_  
 Signature of client or his or her personal representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed name of client or personal representative

\_\_\_\_\_  
 Relationship to client

\_\_\_\_\_  
 Description of personal representative's authority

I acknowledge that I have received a copy of this completed form.

I, Janis B. Rice, M.A., L.P.C., a mental health professional, have discussed issues in this Authorization Form with the client and/or his or her personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

\_\_\_\_\_  
 Janis B. Rice, M.A., L.P.C.

\_\_\_\_\_  
 Date