Client Information for Steve Seliger, LMFT

CLIENT

Name:		
Street Address:	City, State, Zip Code:	
Birth Date:	Is it OK to call you on these numbers?	
Referred by:	Mobile Phone:	y/n
Emergency contact:	Work Phone:	y/n
Emergency contact's phone:	Email:	y/n

PAYMENT

Information about the person who will be responsible for paying the fees for psychotherapy (leave blank if same as client)

Responsible Party:	Home phone:
Street Address:	Work phone:
City, State, Zip Code:	Mobile phone:

HEALTH INSURANCE

Primary Insurance:	Policyholder Name:
Company Address:	Date of Birth:
City, State, Zip Code:	Identification Number:
Company phone:	Policy/Group Number:
Employer:	
Secondary Insurance:	Policyholder Name:
Company Address:	Date of Birth:
City, State, Zip Code:	Identification Number:
Company phone:	Policy/Group Number:
Employer:	

Steve Seliger, LMFT
1104 East Ashton Ave.
Suite 203
Salt Lake City, UT 84106

(801) 661-7697

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 "public health information" or PHI. This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law and the MFT Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

As part of your PHI I keep some specific information in what are called "psychotherapy notes". These notes are kept separate from your medical record and are given much higher privacy protection. They contain my impressions about you and details of the psychotherapy conversation I consider to be inappropriate for the medical record. They contain information pertinent only to my future work with you. They are not available for your review, nor to insurance and managed care companies.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of this 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. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy in our office, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How I 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. I may disclose PHI in this instances only with your authorization.

For Payment: I may use and disclose PHI so that I 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, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: I may use or disclose, as needed, your PHI in order to support my business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services). This is allowed

only if I have a written contract which requires that business to safeguard the privacy of your PHI. For training or teaching purposes your PHI will be disclosed only with your authorization.

Required by Law: There are occasions which require me under law to disclose your PHI with or without your authorization. Some examples are:

- If you are in imminent danger of committing suicide I am legally and ethically bound to intervene in anyway necessary to prevent that including contacting family members and the police
- To the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the Federal privacy requirements,
- If you are at risk of being a serious and imminent threat to the health or safety of a person or the public, I will disclose information to prevent or lessen that serious threat. I will disclose it to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- If there is suspicion of neglect or abuse of a child in the past, present or future I am required by law to report that to the Utah Division of Child and Family Services or the police.
- If I have reason to believe that a vulnerable adult is suffering from abuse, neglect, abandonment or exploitation, I am required by law to make a report to either the Utah Adult Protective Services, or the nearest law enforcement agency as soon as I become aware of the situation.
- Utah law requires that I report the names of any individuals having communicable diseases to the Health Department.
- I may disclose your personal health information in accordance with workers compensation laws.
- If you become involved in the court system a judge can order that I provide information on you. Two examples of this are child custody cases and cases in which clients bring action against therapists.
- I may disclose your PHI pursuant to a subpoena with your permission, court order, administrative order, or similar process.
- I 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
- **I** may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. I will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.
- **I** 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.

With Your Written Authorization: Uses and disclosures not specifically permitted by the circumstances described above will be made only with your written authorization, which may be revoked.

Your Rights Regarding Your PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to Steve Seliger, LMFT, 801 661-7697, 1104 East Ashton Ave., Suite 203, Salt Lake City, UT 84106

- **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 may be 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. I may charge a reasonable, cost-based fee for copies

- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I 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. I am not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. For instance, you can ask me to avoid calling you on selected phone numbers or ask that I send bills to an alternate address.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.
- **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

Complaints

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with me as my own Privacy Officer, Steve Seliger, LMFT. I can be reached at the address at the beginning of this document. Or you may file a complaint with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. I will not retaliate against you for filing a complaint.

Effective Date

The effective date of this Notice is September 2013.

Steve Seliger, LMFT
1104 East Ashton Ave.
Suite 203
Salt Lake City, UT 84106

(801) 661-7697

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 Steve Seliger's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Steve Seliger at the above address.

_____
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***

Consent to Treatment

I understand that my therapist's goal is to provide the best possible service. While I expect benefits from this treatment, I fully understand and accept that because of factors beyond our control, such benefits and desired outcomes cannot be guaranteed. A variety of treatment methods will be used in attempts to provide relief from my symptoms and to improve my coping and problem-solving skills.

I understand that I am ultimately responsible for all charges related to services rendered. I understand that I am encouraged to contact my insurance carrier prior to the start of therapy to clarify my specific coverage, rates of reimbursement, and deductible, in order to fully understand my financial responsibility.

I understand that 24 hour notice is required to cancel or change a scheduled appointment. Otherwise I will be charged for that session (insurance will not cover such a charge). In the event I experience an authentic emergency which prevents me from keeping an appointment, there will be no charge for that session. Due to the nature of a therapist's responsibilities, it may be necessary to reschedule or cancel an appointment on short notice in the event of a medical emergency and/or crisis situation which demands immediate attention.

In the event of an emergency I will call:

1) University of Utah Neuropsychiatric Institute at (801) 583-2500;
2) Salt Lake County Mental Health Suicide Prevention and Crisis Services at (801) 483-5444;
3) 911; or
4) the nearest hospital emergency room.

I have read and understand the above and consent to treatment under the described conditions.

Signature:_____ Today's Date:_____