

NOTICE OF PRIVACY PRACTICES TEXAS

Amber Kuntz, LPCS and Associates
MS, NCC, LPCS

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective of all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change to our privacy practices, we will change this Notice and make the new Notice available upon request.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations.

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization when it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice or allowed under the Law.

To Your Family and Friends: We may disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree, that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health, incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the persons' involvement in your healthcare

Marketing Health - Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel **under** certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence,

counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose a portion of your health information to provide you with results of test, procedures, and/or appointment reminders (such as voicemail messages, postcards, or letters).

Patient Rights

Access: You have the right to look at or obtain copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you .35 for each page, \$35.00 per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you prefer we will provide a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations & certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations, unless we cannot practically do so. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Our Company Policies: Policies

Amber Kuntz, LPCS Counseling and Associates are a private counseling practice with interns, office manager, specialist, group leaders, mentors, and tutors. It is Mrs. Kuntz's policy to not release clinical records unless needed for payment. Mrs. Kuntz is here to help you, though is in no way held liable for self-inflicted harm, harm to self, suicide, and other acts of depression or anger. By signing the policies you do not hold Amber Kuntz LLC and Associates liable for you or your behaviors. You acknowledge we are here to help though, if you have a serious mental illness you may need to be assessed by a local hospital. Warning: Therapy is not always a pleasant experience. In fact, it can be an emotional experience.

For appointments, e-mail ambercounselor@gmail.com or call 940.535.4375. There is a 24-hour cancellation policy. Therapy sessions are 45-50 minutes long. For after hours emergencies, call contact Hotline at 972-233-2233 or 911. All fees are dependent on insurance arrangement and can change. Mrs. Kuntz and staff returns phone calls on a regular basis during office hours. You may leave a detailed message. Phone calls over 10 minutes will be billed at \$2.00 per minute.

Fees and Refund Policy:

Intake session; \$60.00-\$85.00 depending on service and location. Package rates can be negotiated. There is no refund policy. Hypnosis is not guaranteed and there are no refunds. All policies apply in all cases. You may continue on longer at an increase in rate. If fee is not rendered at time of service there will be a \$25.00 fee attachment. If insurance is filed and the insurance company fails to pay, the client is responsible for all fees.

FINANCIAL / INSURANCE:

We ask that at each session you pay 100% of the fee. In the event you have insurance, we will discuss at the intake who will file. If your insurance company denies payment or does not cover counseling, the client is 100% reliable for all fees. In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed plus a \$70.00 fee. We ask that every client authorize payment of medical benefits directly to Amber Kuntz.

Copy of chart is .35 cents per page, \$35.00 per hour clerical fee, \$150.00 per hour redacting fee. As noted in Hipaa policies. There is a retainer fee for all court appearances. Court documentation, consultations, and other specialties should be discussed, as there are increased rates.

Whole Session: Half Session: Sliding Scale: I have received a copy of my fee schedule Client Initial

24-Hour Cancellation Policy:

You will be required to pay for a "no show" or an appointment that is not cancelled within 24 hours. If you are 15 minutes late it is considered a "no show." The 24-hour cancellation policy will apply. You will be charged for that session and we will reschedule your appointment.

Solicitation:

Please refrain from any type of solicitation, enrollment, recruitment, or flirtation in this office. Any conversations that take the focus off of the services you are paying for taints the integrity of pureness of the therapy services you are paying for. In order for me to work with you effectively, you will need to come prepared to turn off cellular phones. You may bring water, but no cigarettes, drugs, or weapons.

If you have something you think I may be interesting in, please put it writing and if I am interested I will contact you about it.

I understand that Amber Kuntz, LPCS and Associates may have a duty to warn. Below is a list of people (but not limited to) that can be contacted in order to help prevent harm.

INFORMED CONSENT

Thank you for choosing Mrs. Amber Kuntz, LPCS and Associates. Today’s intake appointment will take approximately 30–45 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Amber Kuntz and Associates practice standard therapy for most conditions, although other treatment approaches are used depending on the person and/or condition. Treatment practices, philosophy, plan limitations and risks will be discussed with you today. It is the client’s responsibility to discuss any concerns with the staff and to be aware that we are here to support and are not liable for emotional health. If there are signs of serious mental illness client should see a local psychiatrist or be assessed by a local hospital. Our agency is a part of the Delta Society and therefore we use a therapy dog in sessions from time to time. If you are allergic or have problems with a dog being in the office please let us know. We are certified and have had training to be able to serve you with this special service. By acknowledging the below notices you understand this statement.

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

Your verbal communication and clinical records are strictly confidential except for a) information shared with psychiatrist, b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or your child or children report about physical or sexual abuse; then, by Texas State Law, I am obligated to report this information to the Department of Children and Family Services, d) where you sign a release of information to have specific information shared and, e) if you provide information that informs me that you are in danger of harming yourself or others, f) information necessary for case supervision or consultation, g) information you and/or your child or children report about a threat to National Security or a plot of terrorism; then, by the Homeland Security Act, under the regulations and laws of the Federal Government, I am obligated to report his information to the local authorities, and h) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Amber Kuntz, LPCS and Associates will follow those emergency services with standard counseling and support to the client or the client’s family. Amber Kuntz, LPCS and Associates keep treatment plans on clients for all practical purposes and some billing purposes. Treatment plans are kept in client’s chart. I understand that Amber Kuntz, LPCS and Associates use phone and e-mail to correspond with clients, and by signing below I waive my right for her to use these means to discuss the client being my child or myself. Special Note: If Amber Kuntz, LPCS or Associates becomes incapacitated or dies, I give my consent for the person(s) designated by Amber Kuntz to be custodian of my file and to access it for me.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health & Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health & Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health & Human Services.

Acknowledgement of Receipt of "[Notice of Privacy Practices](#)"

Please print out and sign this page and bring it with you to your first appointment

I acknowledge that Amber Kuntz, LPC, NCC, NBCCH, MS. And Associates has given me a copy of the [Privacy Notice](#) either by web, email, US Mail, or in person, (version dated 4/14/03) as required by the federal government’s HIPAA legislation. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Date ____ Printed Name of Client (or Parent) _____ Signature of Client (or Parent) _____

The federal government mandated that as of April 14, 2003 all health care patients are to receive from their clinicians a notice (hereafter referred to as "Notice") regarding the protection of their private health care information in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule (45 C.F.R. parts 160 and 164).

This form documents that Mrs. Amber Kuntz, LPC, NCC, NBCCH, MS and Associates has given you the "Notice" that is required. HIPAA covers what is called "protected health information" (PHI) that is used for treatment, payment, and health care operations. PHI is information in your health record that could identify you.

The Notice contains basic information about:

1. How your PHI may be used and disclosed for treatment, payment and health care operations (these terms are defined in the Notice)
2. Which uses and disclosures require authorization from you and which don't
3. How you may revoke an authorization you have made
4. Certain rights you have to restrict use and disclosure of PHI, to receive confidential communications by alternative means and at alternative locations, to inspect and copy your records, to amend your records, to have an accounting of disclosures
5. A list of my duties to protect the privacy of your PHI, my right to change the privacy policies and practices described in the Notice, and how I will inform you

of changes

6. What you can do if you have any complaints about violations of your privacy rights, about decisions about access to your records I may make

7. Any restrictions and limitations you or I wish to put on the use and disclosure of your PHI.

This page documents that you have received a copy of the Notice.