Denise C. Crowley, LCSW Counseling Services

2055 Limestone Road ~ Suite J
Wilmington, DE 19808~5531
(302)480~2940

Policies and Practices to Protect the Privacy of Your Health Information

HIPAA and CONFIDENTIALITY 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.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations Effective/Last Revised Date: July 1, 2021

Consultation and Counseling is required by federal law to protect the privacy of your health information in the context of your mental health and substance abuse healthcare administered by this agency. I am also required to send you this notice, which explains how I may use information about you and when I can give out or "disclose" information to others. You also have rights regarding your health information described in this notice.

The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

I have the right to change my privacy practices. If I do, I will provide the revised notice to you within 60 days by direct mail or post it in our agency office or on the website.

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

• "PHI" refers to information in your health record that could identify you.

• "Treatment, Payment and Healthcare Operations"

— Treatment is when I provide, coordinate or manage your healthcare and other services related to your healthcare. An example of treatment would be when I consult with another healthcare provider, such as your family physician or another Therapist. Another example would be when I release your treatment plan to your insurance company and/or to your primary care physician.

— Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

— Health Care Operations are activities related to the performance and operation of my practice. Examples of healthcare operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

• "Use" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information which identifies you.

• "Disclosure" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

HOW I USE OR DISCLOSE INFORMATION

I must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the U.S. Department of Health and Human Services, if necessary, to ensure that your privacy is protected; and
- Where required by law.

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about your conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. Please note, I may deny access to your Psychotherapy Notes but will discuss this with you.

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.

III. Uses and Disclosures with Neither Consent nor Authorization

I have the right to use and disclose health information to pay for your health care and operate my business. For example, I may use your health information:

- **To process** claims for health care services you receive.
- **For Treatment.** I may disclose health information to your doctors or hospitals to help them provide medical care to you.
- **For Health Care Operations.** I may use or disclose health information as necessary to operate and manage my business and to help manage your health care coverage. For example, I might talk to your doctor to suggest a disease management or wellness program that could help improve your general health.
- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health related products and services.
- **To Referral Sources.** If you are referred through another agency such as your Primary Care Physician, Juvenile Court, DFS, Psychiatric Hospital, CMHC, etc., I may share summary information and admission and discharge information with the referral source. In addition, I may share other health information with the referral source for case management purposes if the referral source agrees to special restrictions on its use and disclosure of the information.
- **For Appointment Reminders.** I may use health information to contact you for appointment reminders with providers who provide medical or mental health care to you.

I may use or disclose PHI ***without your consent*** or authorization in the following circumstances under limited circumstances:

- **To Persons Involved With Your Care.** I may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- **For Public Health Activities** such as reporting disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, including social service or protective service agencies. If I have reasonable cause to believe a child has been abused, I must report that belief to the appropriate authority. If I have reasonable cause to believe a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.
- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations. If I am the subject of an inquiry by the Delaware Composite Board, I may be required to disclose protected health information regarding you in proceedings before the Board.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena. If you arc involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent, subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person.
- **Serious Threat to Health or Safety.** If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and protective services for the President and others.
- **For Workers Compensation** including disclosures required by state workers' compensation laws relating to job-related injuries. I 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.

- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets all privacy law requirements.
- **To Provide Information regarding Descendants. I** may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. I may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** I may use or disclose information for procurement, banking or transplantation of organs, eyes or tissue.
- If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is my intent to meet the requirements of the more stringent law.

If none of the above reasons applies, **then I will obtain your written authorization to use or disclose your health information.** If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is my intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for me to disclose your highly confidential health information, as described below. Once you have given me authorization to release your health information, I cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if I have already acted based upon your authorization. For information to revoke an authorization, contact the phone number listed on the top of this notice.

HIGHLY CONFIDENTIAL INFORMATION

Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

• *Right to Request Restrictions* — You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to the restriction you requested.

• *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 therapists. On your request, I will send your bills to another address.)

• *Right to Inspect and Copy* — You have the right to inspect PHI in your mental health and billing records (copy of billing) used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process. As your therapist, I may also deny access to your Psychotherapy Notes.

• *Right to Amend*— You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

• *Right to an Accounting* — You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

Therapist's Duties:

• I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

• I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

• If I revise these policies and procedures, I will notify you by mail or on your next session. You may obtain a copy of this notice at the local office or website.

V. Complaints

- If you have any questions about this notice or want to exercise any of your rights, please feel free to inquire**.** Please specify if your question or concern is in reference to your mental health and/or substance abuse protected health information.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a written complaint with me directly.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. **I will not take any adverse action against you for filing a complaint.**

VI. Cancellation Policy

In the Event of an emergency, you will not be charged for session cancellation. Cancellations for any other reasons that are not received by clinic staff at least 24 hours prior to the scheduled session will be billed at the rate of $35 per session. Your insurance company will not pay for missed appointments.

VII. Financial Responsibility

You maintain full responsibility for paying all charges for services rendered. You will need to provide all required insurance information when checking in for services and you will need to update any changed insurance information immediately upon the date of change. All co-payments and unsatisfied deductibles are to be paid at the time of services rendered. I do accept payment by cash or check.

VIII. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on October 1, 2006. 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.

IX. Patient's Consent

I consent for my therapist to disclose my protected health information (PHI) as required by my insurance company. Furthermore, if my insurance company requires coordination of care with my Primary Care Provider (PCP), I consent for my therapist to disclose my protected health information to my PCP. I have read this statement of.'s practices and policies and I both understand and approve of its content.

_____ _____

Printed Name of Client Witness

_____ _____

Signature of Client and/or Guardian Date

Denise C. Crowley, LCSW Counseling Services
2055 Limestone Road ~ Suite J
Wilmington, DE 19808-5531
(302)482-2940 ~ Fax (302)543-6783

Initial Client Questionnaire

Client name: _____ Date of Birth: _____

How did you hear about me? _____

What is the reason for your appointment today?_____

How many psychotherapists/counselors have you seen in past for this problem and related problems? _____

What has been your past experience in psychotherapy/counseling so far?_____

Have you ever been diagnosed with a mental illness? ☐ Yes / ☐ No

Are you presently in psychotherapy/ counseling with anyone? ☐ Yes / ☐ No
If Yes, Who?

Any previous psychological testing? _____ Do you have reports? ____

Have you been hospitalized for psychiatric problems? ☐ Yes / ☐ No. If yes, how many times?___ .
When was the last time?_____

What is your opinion of psychiatric medications? _____

How many psychiatrists have you seen previously for medication management? _____

What has been your experience with medication so for? _____

Have you attempted suicide in the past? ☐ Yes / ☐ No

Do you physically hurt yourself? ☐ Yes / ☐ No

Do you have thoughts of seriously harming yourself or others now? ☐ Yes / ☐ No

Your highest education level: _____

Symptoms:	***YES***	***NO***
Have you been down, depressed, or hopeless in the past month?		
Are you bothered by little interest or pleasure in doing things?		
Has your appetite changed (eating more or less)?		
Has your sleep been disturbed (insomnia or over-sleeping)?		
Do you feel worthless or guilty?		
Do you have sudden or unexpected bouts of anxiety or nervousness?		
Do you often feel tense, worried, or stressed?		
Do you have acute onset of symptoms such as palpitations, shortness of breath, or trembling?		
Do you worry about a lot of different things?		
Do you avoid placed or situations because of anxiety or worry?		
Do you have recurrent, persistent or unwanted thoughts or do repetitive behaviors?		
Have you been through any significantly stressful periods on the past 6 months?		
In your lifetime, have you faced any potentially life-threatening events such as natural disaster, serious accident, physical or sexual assault/abuse, military combat or child abuse?		
Since you experienced any of these stressors, have you been easily startled?		
Angry or irritable?		
Emotionally numb or detached from your feelings?		
Prone to physical reactions when reminded of the event?		
Do you use prescription medicines or street drugs to relax, calm your nerves, or get high?		
Have you made an effort to cut down on your drinking or drug use?		
Have you been annoyed by people who criticize your drinking or drug use?		
Do you ever feel guilty about your drinking or drug use?		
Do you ever drink or use drugs to steady your nerves, get rid of a hangover, or relieve withdrawal symptoms?		

Your occupation / work: _____

Did you have a happy childhood? ☐ Yes / ☐ No

Where you raised by your parents? ☐ Yes / ☐ No

How was your relationship with your parents growing up? _____

How is your relationship with your parents now? _____

Were you abused or molested as a child? ☐ Yes / ☐ No

How many times have you been married? _____

Who do you presently live with? _____

Do you have any children? If so, how many? _____

Are there major problems in your present household?_____

Who is supportive of you at this time?_____

Are you facing any legal difficulties at this time? ☐ Yes / ☐ No

How much difficulty are you having presently in functioning at your work/ home life/school?
_____

What religious and spiritual values are important to you? _____

What are some of your strengths and abilities? _____

What are some of your needs? _____

Do you have any specific preferences for your care ? Yes __ No __

If yes, please describe: _____

Substance Use history:

Substance	Age at First Use	Date/Age at Last Use	Duration & Frequency of Use
Alcohol			
Marijuana			
Methamphetamines			
Amphetamines			
Cocaine			
Benzodiazepines			
Barbiturates			
Hallucinogens			
Opiates (Prescription)			
Methadone			
Heroin			
PCP (Angel Dust)			
Inhalants			
Prescription Drugs			
Other illicit Substances			
Caffeine			
Tobacco (smoking/chewing)			

Have you ever had treatment for substance-abuse? ☐ Yes / ☐ No

Do you have any medication allergies? ☐ Yes / ☐ No; If yes, describe: _____

Environmental/food allergies? ☐ Yes / ☐ No; If yes, describe: _____

Family history of psychiatric illness:

Problem/Illness	In Which Family Member
Nervous breakdown	
Depression	
Bipolar disorder	
Anxiety/panic	
Drug abuse	
Alcohol abuse	
Suicide with a gun	
Suicide (other)	
Violent crime	
Survivor of abuse	
Abuser or Molester	

Circle all problems present now or in past:

Allergies	Asthma	Chronic cough/bronchitis	Snoring
Chest pain	Heart problems	Palpitations	Mitral valve prolapse
Swelling of feet	High blood pressure	Thrombosis	On blood thinners
Problem with urination	Miscarriages	Sexual problems	Sexually Transmitted Diseases
Abortions	HIV	Weight gain	Weight loss
Diarrhea	Constipation	Liver problems	Heartburn/indigestion
Stroke	Headaches	Ringing in ears	Hearing aids

Vision problems	Thyroid problems	Infections	TB
Genetic Problems	Diabetes mellitus	High sensitivity to medications	Seizures
Nausea and vomiting	Arthritis/muscle pains	Numbness or tingling	Other problems:

Family history of physical illness:

Problem/Illness	In Which Family Member
Diabetes	
Heart disease	
Sudden-death	
Other major illness	

Who is your Primary Care Physician? _____

Other doctors seen regularly: _____

Current non-psychiatric medications: _____

_____

Is there any other information you would like your therapist to be aware of?

_____

_____

_____

_____

Denise C. Crowley, LCSW Counseling Services
2055 Limestone Road ~ Suite 200-J
Wilmington, DE 19808-5536
(302)482~2940 PHONE (302)543~6783 FAX

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ Date of Birth: _____

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting our office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, legal/court records, educational records, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above identified patient. I authorize these agencies to share information by mail, phone, in person, fax and/or email contact. I understand these records are protected by Federal and State laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

☐ I hereby authorize _____ to RELEASE my protected health information (PHI) to:

_____

☐ I hereby authorize _____ to OBTAIN my protected health information (PHI) from:

_____

Disclosure Scope for PHI Release:

Disclosure may include the following verbal or written information: (check all that apply)

☐ Face sheet ☐ History & physical ☐ Laboratory/diagnostic testing results ☐ School information

☐ Discharge summary ☐ Medication records ☐ Behavioral health/psychological consult

☐ Psycho-social assessment/Family history ☐ ER record report ☐ Psychiatric evaluation

☐ Substance abuse treatment records ☐ HIV/AIDS lab results & treatment history

☐ Progress & Case Notes ☐ Summary of treatment records & contact dates

☐ Psychological evaluation/testing results ☐ Other:_____

☐ Information necessary to identify, diagnose, prognosis, or treatment for mental health, substance abuse (alcohol/drug use), and any other relevant information for the purpose of treatment.

All information I hereby authorize to be obtained from the above identified source will be held strictly confidential and cannot be released by ***Denise C. Crowley, LCSW Counseling Services*** without my written consent. I understand this authorization will remain in effect for:

☐ The period necessary to complete all transactions on accounts related to services provided to me.

☐ One (1) year

☐ Other:_____

I understand unless otherwise limited by State or Federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. If client is a minor child, I verify I am the legal guardian/custodian of this child.

_____ _____

Signature of Client/Legal Guardian or Legally Authorized Representative *Date*

_____ _____

Witness *Date*