Notice of Privacy Practices
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 Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.

Living Tree Wellness Center, LLC is required by law to maintain the privacy of PHI and to provide you with notice of legal duties and privacy practices with respect to PHI. Living Tree Wellness Center, LLC is required to abide by the terms of this Notice of Privacy Practices. Living Tree Wellness Center, LLC reserves the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that Living Tree Wellness Center, LLC maintains at that time. Living Tree Wellness Center, LLC will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on my website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

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. **Living Tree Wellness Center, LLC may disclose PHI to any other consultant only with your authorization.**

PHI will be shared if it becomes necessary to use in the collection processes due to lack of payment for services, Living Tree Wellness Center, LLC will only disclose the minimum amount of PHI necessary for purposes of collection.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit me to

disclose information about you without your authorization only in a limited number of situations.

As a licensed mental health therapist in this state, it is my practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with HIPAA.

Child/ Elder Abuse or Neglect. Living Tree Wellness Center, LLC may disclose your PHI to a state or local agency that is authorized by law to receive reports of child/elder abuse or neglect.

Judicial and Administrative Proceedings. Living Tree Wellness Center, LLC may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Medical Emergencies. Living Tree Wellness Center, LLC may use or disclose your PHI in a medical emergency to medical personnel only in order to prevent serious harm.

Law Enforcement. Living Tree Wellness Center, LLC may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Fees

Initial intake (90 min session) …….$120
Regular session (50 min session) …..…….. $110

Payment is due at the beginning of each session.

If I am an out of network provider, and will provide you with a monthly statement to submit to your insurance company. Check with your insurance carrier to find out what their out of network coverage is.

Please sign below that you agree and understand the financial responsibility:

_____

Client Signature Date

_____

Print name

Consent to Treat

Please sign below to show you have read and understand the forms given to you, and that you consent to the recommended treatment and/or grant permission for treatment to be provided to yourself or your child.

_____

Client Signature Date

_____

Print name