Caasi O'Day, LCSW

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Practice Guidelines and Consent to Treatment Form

Welcome to The Cairn Center. A successful working relationship between clinician and patient requires that both of us understand and adhere to certain guidelines. The following policies are designed to avoid any unnecessary confusion and to help me provide you with a higher quality of care. Please take a moment to review and sign this Consent to Treatment.

APPOINTMENTS

Your appointment time is reserved for you and you alone (I do not overbook). I will make every effort to be punctual, and I request that you do the same. *I do not like to keep my patients waiting, if you arrive more than 10 minutes late for your appointment you may be asked to reschedule*. If you need to cancel an appointment, please do so at least 24 hours before your appointment by calling (702)-508-9461. By notifying me in advance, you allow me to remain flexible in accommodating other patients who need to be seen. *If you do not provide notice of a cancellation 24 hours before your scheduled appointment, you will be charged the full fee for the missed appointment*. Monday appointments must be cancelled before the weekend to avoid your being charged. Be advised that insurance plans do not pay for missed appointments.

PSYCHOTHERAPY

Since the goal of therapy is to help you see things about your life in a new way, it may at times reveal painful aspects of your life or stir emotional distress. The working relationship of psychotherapy is unique. Feelings about me may be an important part of the treatment, and we should discuss them regardless of whether they are negative or positive. Although it is unlikely, there is a possibility that the treatment could make you feel worse or uncover more severe illness, in which case I would, with your permission, take all appropriate steps to help you overcome this.

CONTACTING ME

I am available should issues arise, and I will make every effort to return your call the same business day. I do not accept calls when I'm in session, so please leave me a detailed message and I'll get back to you. For those of you that prefer to communicate via email, you can do so at odaylcsw@yahoo.com . In the event of a weekend or after-hours emergency, call 702-508-9461 to try and reach me. But if you can't reach me quickly in the case of an emergency, call 911 or go to a hospital emergency room.

E-MAILS, FAX COMMUNICATIONS

It is very important to be aware that computers, e-mail and cell phone communication can be relatively easily accessed by unauthorized people and, hence, can compromise the privacy and confidentiality of such communication. E-mails in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Additionally, Caasi O'Day's e-mails are not encrypted. Faxes can easily be sent erroneously to the wrong address. Please notify Caasi O'Day if you decide to avoid or limit, in any way, the use of such communication devices. Patients should not use e-mail for medical emergencies or to send time-sensitive information to providers. Patients should understand and agree that it is their responsibility **to follow up** with the clinician if they have not received a response to an e-mail within a reasonable time period. At your health care provider's discretion, your email messages and any and all responses to them may become part of your medical record.

CONFIDENTIALITY AND RIGHT TO PRIVACY

Privacy and confidentiality is a cornerstone of psychotherapy. Clinicians are required by law to protect the privacy of your protected health information (PHI). A copy of the Notice of Privacy Practices has been made available to you and it is also posted on our website at www.cairncenter.com. No information will be released without your written consent unless mandated by law.

<u>Use and release of your health information without your authorization:</u>
While Caasi O'Day is providing you psychotherapy, she may need to share your health information with other health-care providers, or other individuals who are involved in your treatment. Examples include: other therapists and/or physicians. In addition, Caasi O'Day may need to share health information in the following cases:
Required by law—Sometimes clinicians must report some of your health care information to legal officials or authorities, such as law enforcement officials, court officials, governmental agencies, or attorneys. Examples include: reporting suspected abuse or neglect, reporting domestic violence or certain physical injuries, or responding to a court order, subpoena, warrant, or lawsuit request, complaints to state medical boards
Public Health Activities—The Cairn Center office may be required to report your health information to authorities to help prevent or control disease, injury, or disability. Examples include: reporting certain diseases, injuries, birth or death information; information of concern to the Food and Drug Administration; or information related to child abuse or neglect.
Health Oversight Agencies—Caasi O'Day may be required to release health information to authorities so they can monitor, investigate, inspect, discipline or license those who work in the health-care system, or for governmental benefit programs.
To Avoid a Serious Threat to Health or Safety—The Cairn Center may be required by law and standards of ethical conduct to release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to anyone's health or safety.
Military, National Security, or Incarnation/Law Enforcement Custody—The Cairn Center may be required to release your health information to the proper authorities so that they may carry out their duties under the law. This applies only if you are in the military, involved in national security or intelligence activities, or if you are in the custody of law-enforcement officials.
Worker's Compensation—if applicable
<u>Use and release of your health information requiring your authorization:</u>
Persons Involved in Your Care—In certain situations, we may release health information about you to persons involved with your care, such as friends or family members. You have the right to approve such releases, unless you are unable to function, or if there is an emergency. Please list your <u>preferred emergency contact</u> on the Consent/Release of Info Page.
Except for the situations described above, your authorization is required for any other types of release of your health information. If you provide Dr. Jain with authorization to use or release health information about you, you may cancel that authorization in writing at any time.
By signing the Consent to Treatment form, you are agreeing to let us collect, use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information. You are also releasing me and holding me harmless for any departure from the right of confidentiality that may result. **If you do not sign this form agreeing to our privacy practices, we cannot treat you.**
For all patients, I keep records describing the patient's clinical condition and treatment, but I avoid documenting potentially embarrassing personal information if I can do so in a manner consistent with medical responsibility. Psychotherapy notes have a high level of protection under the HIPAA (Health Insurance Portability and Accountability Act of 1996) privacy regulations. Their contents may not be divulged without your specific authorization, which is not permitted to be required as a condition of insurance coverage.
You have the right to view your medical records (but not psychotherapy notes) and request amendments within a reasonable period of time except in limited legal or emergency circumstances or when Dr. Jain assesses that releasing such information might be harmful in any way. In such a case I will provide the records to an appropriate and legitimate mental health professional of your choice. If you give consent to release for release of medical information from your record, in compliance with HIPAA, I will disclose only the minimum amount of information necessary to serve the purpose for which the request has been made.
If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked.
After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

CONFIDENTIALITY AND THIRD PARTY PAYERS
You should be aware that any information given at your request to an insurance or managed care company is thereafter beyond my control. I will try to provide only the minimum necessary information to your carrier. Health insurance companies sometimes give information to the Medical Information Bureau or the National Medical Data Bank, which may affect your future eligibility for life, disability, or other insurance. Some employers obtain identifiable data from administrators of their health insurance. Medicare and other insurance plans have the right to inspect the medical records of subscribers who file claim. In my experience, such events are rare, and I would resist them to the greatest extent legally possible, but it my duty to let you know of the possibility.

LITIGATION LIMITATIONS
Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on Caasi O'Day to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon; unless Caasi O'Day and you have decided otherwise.

PAYMENT FOR SERVICES
I understand that I am responsible for payment of services rendered to me. I also understand that payment is due at the time the service is rendered. Returned checks will be subject to a $30 administrative fee. The fee for therapy is $90.00 for a 50 minute session or $150.00 for an 80 minute session. I understand that the fee for therapy may change and I will be given notice prior to my next appointment being made. Please notify Caasi O'Day if any problems arise during the course of treatment regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to you and not to the insurance company. Unless agreed upon differently, Caasi O'Day will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement, if you so choose. Not all issues/conditions/problems dealt with in psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If your account is overdue (unpaid) and there is no written agreement on a payment plan, Caasi O'Day can use legal or other means (courts, collection agencies, etc.) to obtain payment.

PAYMENT FOR UNUSED APPOINTMENTS
I understand that I am responsible for keeping and paying for my appointments. I also understand and consent to pay full charge for the appointment if I do not cancel more than twenty-four hours before my scheduled appointment time, unless Caasi O'Day and I agree that something truly unforeseeable intervened.

CONSENT TO TREATMENT
I, voluntarily, agree to receive Mental Health assessment, care, treatment, and authorize the Caasi O'Day to provide such care as is considered necessary and advisable in her professional judgment. I agree to participate in the planning of my care and I may stop treatment at any time by informing my therapist. I have both read and understood all the terms and information contained herein.

______________________________ ______________________

Client Signature Date

______________________________ ______________________

Clinician Signature Date

☑ This copy has been made available to the patient/ parent/ personal representative