CATHOLIC CHARITIES
DIOCESE OF ARLINGTON

FAMILY SERVICES

Clinician: _____
Location: _____
Direct Phone: _____

All Family Services Counseling Locations

Northern / Western Region 703-425-0109		**Southern Region 540-371-1124**
Fairfax Arlington Alexandria Mclean Vienna Burke	Ashburn Leesburg Purcellville Sterling Manassas	Fredericksburg Colonial Beach Dale City Lake Ridge Spotsylvania Stafford Triangle

Dear Family Services Client,

On behalf of the agency, I'd like to extend to you a warm welcome and to assure you of our commitment to providing a service that is caring, confidential, and of the highest professional quality.

With the enclosed materials, we introduce our services to you. We respect the unique, diverse needs of our clients. In addition, we are able to make services available in Spanish. Please note that we are a Catholic agency. Our mission is to provide services grounded in a Catholic understanding of the human person to anyone in need regardless of his or her religious preference. We provide clinical services with the utmost respect for the dignity of each person, and a goal of assisting each person in achieving optimal healing and growth.

Our therapists are available to anyone within the geographical reach of our offices who is in need of outpatient individual, marital, child, or family counseling. We have offices in 19 locations in Virginia. Appointments are made by calling the main intake number in Fairfax [703-425-0109] or Fredericksburg [540-371-1124].

Although we are supported by generous donors, we do also rely on client fees to support our service. If you have not yet done so, please contact our intake coordinator to discuss the setting of your fees or insurance.

Please take a few minutes to fill out the enclosed forms, which will assist your therapist in providing you with a service that is specific to your needs. The additional pages of materials are for your understanding and will be reviewed with you by your therapist at the beginning of services. Please retain a copy of this packet for your future reference. If you have a disability or special need that may affect your participation in our service, please let us know. Be assured that this information will be kept confidential.

Thank you for choosing our service. We welcome your comments, questions or suggestions at any point in your experience of working with us.

Sincerely,

Michael Horne, PsyD
Director, Clinical Services

Contents

CATHOLIC CHARITIES DIOCESE OF ARLINGTON, INC.

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 IT CAREFULLY.

This Notice applies to all Behavioral Services provided by the following departments of the Catholic Charities Diocese of Arlington, Inc.:

- Family Services Mental Health Counseling
- St. Margaret of Cortona Family Transformational Housing
- Christ House Men's Transformational Housing
- Mother of Mercy Free Clinic

These departments are committed to protecting your health information and are required by law to protect the privacy and security of your protected health information.

The purpose of this Notice is to explain to you our legal duties and privacy practices regarding your health information and how we may use or disclose your health information. This Notice also explains your rights to your health information and the steps we will take to notify affected individuals in the event of a breach of unsecured health information. Catholic Charities Diocese of Arlington (CCDA) is required to abide by the terms of this Notice and to give you a copy of this Notice.

We will not use or disclose your health information other than as described in this Notice unless you sign a written authorization that tells us we can. If you sign a written authorization and change your mind, you can tell us in writing at any time. We will notify you promptly if a breach occurs that may affect the privacy or security of your health information.

How We Use and Disclose Your Health Information

The CCDA uses your health information to provide you with health care, to process and receive payment for health care provided to you, and to administer our operations. In some cases, your health information may only be disclosed with your written authorization, and in other instances, your authorization is not required. The details of the CCDA's uses and disclosures of your health information are described below.

CCDA does not use or disclose your health information for marketing purposes nor sells health information.

Uses or Disclosures Requiring Written Authorization

We will not use or disclose your health information without your written authorization, except as described in in this notice.

Psychotherapy notes. We will not use or disclose psychotherapy notes without your authorization except for certain treatment, payment and healthcare operations and in certain other limited instances.

Written Authorization. If you sign an authorization allowing us to use or disclose your health information, you may revoke your authorization in writing at any time. The revocation will be effective except to the extent that CCDA already has taken action in reliance on your authorization prior to your revocation.

Once your health information has been disclosed pursuant to your authorization, the federal privacy protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your or CCDA's knowledge or authorization. To revoke an authorization, you must provide CCDA with a hardcopy written notice withdrawing authorization to disclose your health information.

Treatment, Payment, and Health Care Operations Without Your Authorization

Treatment. CCDA may use and disclose your health information for treatment purposes without your authorization. For example, if you are being treated by a physician, CCDA may disclose your health information to that physician to help him or her treat you.

Payment. CCDA may use and disclose your health information without your authorization so that we can be paid for health care we have provided to you. For example, we may need to disclose your health information to your health insurance company so that we can be paid for services we provided to you. We also may contact your health insurance company to find out what services are covered by your health plan, to get prior approval for treatment, and to tell them about your treatment to make sure they will pay for the services we provide to you.

Health Care Operations. CCDA may use or disclose your health information without your authorization so that we can operate efficiently, effectively and in the best interests of our clients. CCDA may use your information in certain administrative, financial, legal, or quality assurance functions. An example of this would be an internal review of cases by CCDA staff to ensure the quality of our clinical services.

Other Uses and Disclosures That Do Not Require Your Authorization

CCDA also is permitted or required to share your information in other ways that do not require your authorization:

- **Business Associates.** In some instances third parties known as business associates provide services to CCDA. We may disclose your health information without your authorization to our business associates. We require our business associates to ensure that health information is appropriately safeguarded and protected from unauthorized use or disclosure. In addition, business associates are required by law to maintain the privacy and security of health information.
- **Personal Representatives**. Your health information may be disclosed to people you have authorized or people who have the right to act on your behalf. Examples of personal representatives are parents of minors, and those who have medical power of attorney or are legal guardians of adults.
- **Required by Law.** We will use or disclose your health information when required by federal or state law. CCDA may disclose your health information if we believe you are a danger to yourself or danger to others.
- **Judicial and Administrative Proceedings**. We may disclose health information in the course of a judicial or administrative proceeding pursuant to a court or administrative order, subpoena, discover request or other lawful process.

- **Public Health Activities.** We may use or disclose your health information for public health activities when authorized by law. For example, we may disclose your health information for public health activities that involve preventing or controlling disease, injury or disability.
- **Abuse, Neglect or Domestic Violence**. We may disclose your health information as required by Virginia law to law enforcement or other agencies such as local police, Child Protective Services or Adult Protective Services if we believe you are the victim of abuse, neglect or domestic violence. CCDA is required by law to report to Protective Services cases of suspected abuse, neglect or domestic violence toward children, incapacitated adults over 18, and adults over 60.
- **Health Oversight**. We may disclose your health information to a health oversight agency for oversight activities authorized by law the health care system for audits, investigation, licensure, and other oversight activities.
- **Law Enforcement**. We may disclose your health information to law enforcement under certain conditions consistent with applicable law or when requested by law enforcement under certain conditions.
- **Military and Veterans Activities**. If you are Armed Forces or foreign military personnel, we may disclose your health information to comply with laws related to military service or veterans affairs.
- **National Security and Intelligence Activities**. We may disclose your health information to authorized federal officials for the conduct of lawful intelligence, counter-intelligence and other national security activities authorized by law, and to protect the President of the United States, other authorized persons or foreign heads of state.
- **Worker's Compensation**. We may use or disclose your health information in order to comply with laws related to worker's compensation.
- **Research**. Under certain circumstances, we may use or disclose your health information for research purposes, as long as the procedures required by law to protect the privacy of the research data are followed. Research must be approved through a special process that is designed largely to protect the privacy of health information.
- **Deceased Individuals**. The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

Uses and Disclosures Requiring An Opportunity to Agree or Object

Notification to Others Involved In Your Care. In some circumstances, we may disclose your health information to a family member, other relative, close personal friend, or other person involved in your care or payment for your care. We also may use or disclose your health information to notify or assist in notifying a family member, personal representative, or another person responsible for your care or disaster relief organization about your general condition, location (such as in the hospital) or death. If you do not want this information to be used or disclosed, you may object.

YOUR HEALTH INFORMATION RIGHTS

When it comes to your health information, you have certain rights.

Access to Your Health Information

You have the right to see or receive an electronic or paper copy of your health record. Certain exceptions apply under law, including exceptions for psychotherapy notes. We will provide a copy or a summary of your health information, usually within 30 days of your written request. We may charge a reasonable cost-based fee. If you are denied access to your health record, you will be notified and provided information on your rights to appeal the decision. Ask us how to see or receive a copy of your health record.

Request Confidential Communications

You have the right to request that we communicate your health information by alternative means or in an alternative location. For example, you have the right to request ask that we only contact you at your home or office phone. We will accommodate your reasonable requests.

Request Amendment to your Health Information

You have the right to request that CCDA amend your health information if you believe the information is incorrect or incomplete. We may say "no" to your request, but will tell you why in writing within 30 days. Ask us how to have corrections made to your health record.

Obtain a list of Disclosures of your Health Information

You have the right to request a list (accounting) of our disclosures of your health information. The accounting is a list of disclosures of your health information by CCDA to others, except that disclosures for treatment, payment or health care operations, disclosures made to or authorized by you, and certain other disclosures are not part of the accounting. The accounting covers up to six years prior to the date of your request. You may request an accounting that covers a period that is less than six years.

Ask us how to get a list of disclosures. We will provide one accounting per year for free but will charge you a reasonable, cost-based fee if you ask for another list within 12 months.

Right to Limit Use or Sharing of your Health Information

You have the right to request to ask us not to use or share certain health care for treatment, payment or our health care operations. We are <u>not</u> required to agree to your request, and we may say "no" if agreeing to your request would affect your care.

If you pay for a service or item out-of-pocket in full, you can ask us not to share that information for the purposes of payment or our health care operations or with your health insurance company. We will say "yes" unless we are required by law to share the information.

Right to Have Another Person Act for You

You can have another person exercise your rights if that person is legally authorized to do so. For example, you

have given that person medical power of attorney or that person is your legal guardian. A parent may exercise their child's rights by consenting to treatment or requesting health information with certain limitations.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may also obtain a copy of this Notice at our website at http://www.ccda.net/programs_family.php.

Right to Complain

You have the right to complain to CCDA and/or to the U.S. Department of Health and Human Services if you believe your privacy rights have been violated. We will not retaliate or discriminate against you; and no services, payment, or privileges will be withheld from you because you file a complaint.

To file a complaint with us, submit your complaint in writing to (you do not need to come to in person to file a complaint) to one of the addresses identified at the end of this Notice

To file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights, send a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, call 1-877-696-6755, or visit www.hhs.gov/ocr/privacy/hipaa/complaints/.

EMERGENCY CARE

Family Services is not an emergency care service. If you have an emergency, call 9-1-1 or *CrisisLink at* 703-527-4077 or 1800 273 TALK (1 800 273 8255) or go to the nearest hospital emergency room. For information and referrals to over 4,400 social service programs in Virginia, call CrisisLink at 211.

SAFE WORK ENVIRONMENT

Firearms and Weapons Prohibited

It is the policy of Catholic Charities of the Diocese of Arlington, VA, to maintain a safe work environment for all persons, including our clients, staff, and guests. Possession of firearms and weapons at a CCDA location, including Satellite Offices, are prohibited regardless of any license or permit that an individual may have which would otherwise authorize the individual to carry firearms or weapons.

Threat or Harm by Client

Any verbal or physical threat, or harm, to a CCDA employee by a client, will result in immediate termination of therapeutic services. Documentation of any threat or harm will be dictated in the client's file. The therapist will provide the client with three mental health referral sources via letter, phone call, or in-person. Law enforcement will be contacted, if warranted.

CHANGES TO THIS NOTICE

This Notice is effective as of February 4, 2020.

We reserve the right to change the terms of this Notice at any time. Any changes we make will apply to all of your health information that we maintain, including health information that was created or received before the effective date of the change. If we make a change to this Notice, we will make a paper copy of the revised Notice available upon request, and post the revised Notice at our locations and on our website at http://www.ccda.net/programs_family.php.

QUESTIONS

If you would like further information or have any questions about this Notice, please contact:

Dr. Michael Horne
Director, Clinical Services
Catholic Charities Diocese of Arlington
1101 Stafford Avenue
Fredericksburg, VA 22401
P: 540.371.1124

Maggie Ma
Director, Quality Assurance, CHP
Catholic Charities Diocese of Arlington
200 N. Glebe Road, Suite 506
Arlington, VA 22203
P: 703.224.1644

Acknowledgment of Receipt of Notice of Privacy Practice

I have been informed of Catholic Charities Diocese of Arlington's privacy practices and understand my rights. I understand the protections and exceptions to confidentiality that may apply to my health information. I acknowledge that I have been given a copy of the Notice of Privacy Practices and I understand that I may ask questions at any time during my services.

Client Signature	Date
Co-Client Signature	Date
Therapist Signature	Date

FAMILY SERVICES CLIENT STATEMENT OF RIGHTS AND RESPONSIBILITIES

The following information is provided to ensure a clear and mutual understanding of your rights and responsibilities as a client in counseling. Please read this information carefully and initial each section. You may ask about any information that is not clear. Your signature and initials indicates consent.

CLIENT'S RIGHTS

TREATMENT

You have the right to participate in the development of any personalized service or treatment plan and the right to refuse recommended treatment and/or referral services. However, Family Services reserves the right to terminate services and treatment if you refuse to participate in recommended services and/or treatment. You have the right to know the cost to you for services and treatment. Additionally, an appropriate referral will be made if your needs exceed our resources as an outpatient mental health provider.

Initial _____ / _____

PROFESSIONALISM

Family Services is dedicated to providing treatment and services grounded in a Catholic understanding of the human person that meet the highest standards of professionalism and ethical responsibility. You have the right to know the professional qualifications of your therapist and you may inspect a copy of their credentials, or request a copy of their supervisor's credentials, at any time and you may inquire about his/her training and experience.

Initial _____ / _____

CONFIDENTIALITY

Family Services takes your privacy seriously. Client information will not be released to or reviewed with anyone outside of the agency except at the specific written authorization of the client or personal representative. Please be aware that if two adults are seen together, all parties must give written permission to release or review requested information.

Family Services complies with all federal HIPAA regulations regarding protected health information. Your health information is treated as confidential as described in our *Notice of Privacy Practices*.

In order to provide the best service possible, your Family Service counselor may consult with other clinicians from time to time. Also, CCDA Quality Assurance standards require a review of a random sample of case records on a quarterly basis. Please ask your therapist if you have any questions about these processes. For a complete explanation of confidentiality protections and exceptions, please refer to the enclosed *Notice of Privacy Practices.*

Initial _____ / _____

DISCLOSURES
You have the right to access your health record or give permission to disclose information with others. If two or more adults are part of the mental health record, both parties must sign the authorization for disclosure of information. Authorizations must be completed in consultation with your therapist and you have the right to revoke an authorization any time in writing prior to the disclosure of information. A fee may apply and you will be notified in advance.

Initial _____ / _____

GRIEVANCES
If you have any doubts or complaints about the conduct of your therapist or the treatment or services you receive, you have the right to contact the Director of Clinical Services. You may make a written complaint and be assured of a written response that is prompt, well considered, and personal.

Initial _____ / _____

CLIENT'S RESPONSIBILITIES

TREATMENT
You agree to participate in setting goals for counseling and in evaluating these goals as your treatment progresses. Evaluation includes following through on agreed upon goals, and informing your therapist about your progress toward meeting the goals.

Initial _____/ _____

FEES AND BILLING
You have the responsibility to pay fees at the time of each appointment, according to the negotiated rate, unless specific alternate arrangements are made. For some, medical insurance will pay part of the cost of counseling. Deductibles, co-payments and balances not covered by medical insurance are your responsibility. Financial assistance is available for qualifying individuals (verification of income is required).

Service fees are collected by your therapist at the end of each appointment by cash, check or credit card. Please be aware that funds collected will be applied to the oldest outstanding invoice first. It is your responsibility to keep your account current each session. Family Services relies in part on your service fee or co-pay in order to sustain quality counseling services and we are not able to waive our service fees or co-pays.

If you have specific payment concerns or questions, you may reach our Billing Department during business hours by calling **703-224-1639**.

Initial _____ / _____

CANCELLATIONS

You are responsible for setting and keeping scheduled appointments. If you do not show up for an appointment or fail to give 24 hour notice (not including weekend time) that you need to cancel your appointment you will be charged a "no-show" fee**. <u>The "no show" fee will be your usual fee, your co-pay if you have medical insurance that covers your counseling, or $25, whichever is less.</u>** Multiple occurrences of missing scheduled appointments without notice will lead to suspension of services. There may be a significant delay in resuming services and you may not be guaranteed placement with your former therapist.

Initial _____ / _____

COMMUNICATION

All communication between you and your therapist should be conducted in private in-person counseling sessions in order to maintain the quality, privacy and confidentiality of services. It is for your privacy and protection that Family Services will not engage in counseling, treating, or consulting clients outside of the private counseling office setting.

Scheduling appointments will be directly communicated between you and your therapist during appointment times. You may call your therapist directly to schedule or change future appointments when needed. Please coordinate with your therapist to receive their direct business phone number at the beginning of services. All general inquiries can be addressed by calling: **Fairfax: 703-425-0109** or **Fredericksburg: 540-371-1124**.

Mental health concerns or counseling related questions must be called in directly to your therapist. If you are having an emergency, call 911 or go to the nearest emergency room. Please be aware that Family Services staff may not be able to address your call until your next scheduled session.

Initial _____ / _____

EMAIL

Family Services does not use email for conducting counseling services, which includes diagnosing, consulting or treating clients. This includes Email, Text Messages, Skype, Face Time, or other tele-therapy methods. Email is not a secure form of communication and does not provide the quality of service needed for mental health counseling.

If emails are exchanged that contain clinically relevant protected health information, the information will become part of the mental health record. These emails may be disclosed in accordance with future authorizations or legal requirements. Clinically relevant email messages will be documented in the mental health record system at the therapist's discretion. Email is part of the record when it contains identifying health information or contains information that can be used by your therapist in any form to make an assessment, diagnosis or recommendation about your health. Highly sensitive or personal information should only be communicated in-person or over the phone; email is not the preferred method to communicate with Family Services.

Initial _____/ _____

COURT

Family Services does not provide forensic evaluation services and is unable to engage in court proceedings involving child custody in divorce or separation litigation unless responding to a subpoena by the court. Any legal action including subpoena for documents or disclosing protected health information in connection to a court case will require written authorizations. Please be aware that mental health records for marital counseling will only be disclosed based on written authorizations of both parties.

If you or an attorney subpoena a therapist for court testimony, you agree to pay the full clinical fee for the therapist's preparation, travel, waiting, and testifying time. The hourly fee is $125. These charges will apply even if the therapist is excused from testifying.

Written requests for information will be processed as promptly as possible. Please ensure that you provide your therapist timely information regarding any legal proceedings and you can discuss the process for disclosure of information. Family Services is not responsible for meeting court dates if your written authorization is not completed by you in a timely manner.

Initial _____ / _____

EMERGENCY CARE

Family Services is not an emergency service. If you have an emergency, call **9-1-1** or ***CrisisLink at* 703-527-4077 or 1800 273 TALK (1 800 273 8255) or go to the nearest hospital emergency room. For information and referrals to over 4,400 social service programs in Virginia, call CrisisLink at 211.**

Initial _____ / _____

Acknowledgment of Receipt of Client's Rights and Responsibilities

I have read, understand, and agree with my rights and responsibilities and provided my initials. I also acknowledge that I have received a copy of the Client's Rights and Responsibilities for my records.

Client Signature	Date
Co-Client Signature	Date
Therapist Signature	Date