



Maria Allen-Jenkins, Psy.D., PLLC

Policy Binder

Welcome! I appreciate the opportunity to work with you. The following is intended to inform you of the policies of Maria Allen-Jenkins, Psy.D., PLLC and to assist you in having a positive counseling experience.

I. **Session Length**

- A. Sessions last **45 to 60 minutes** unless prior arrangements have been made for longer sessions to take place. Some insurance companies will not approve sessions lasting longer than 50 minutes.

II. **Fees for Service**

- A. The initial session is \$200.00 and each therapy session thereafter is \$175.00. Payment will be expected at the time of service unless prior arrangements have been made.
- B. If insurance is being filed, a co-payment, co-insurance, or deductible payment will be due at each session as required by insurance.
- C. Cash, check, or credit card is accepted.
- D. There will be a \$30.00 service charge applied to your account for all returned checks.
- E. For additional fees refer to the “Professional Fees” portion on page 3.

III. **Missed or Late Sessions**

- A. A \$30.00 fee will be assessed for all sessions that are not cancelled with at least a **24 hour notice**, with the exception of an emergency. Note that insurance companies do not pay for late cancellation fees.
- B. A \$60.00 fee will be assessed for all sessions that are missed with no cancelation, with the exception of an extreme emergency. Note that insurance companies do not pay for “no show” fees.
- C. If you arrive late for a session, the session will end at the regularly scheduled time. Insurance will not always pay for these shortened sessions, in which case you will be responsible for the full session fee.

IV. Emergency Access

- A. I am available by phone (502) 709-8850, but am not always able to immediately return calls.
- B. If immediate assistance is needed before I am able to return your call, you may call 9-1-1, call the crisis hotline at 502-589-4313, or go to the nearest emergency room. In the event of going to the hospital for a mental health issue, please notify me as soon as is reasonable.

V. Confidentiality

- A. The issues that are discussed in your sessions are between me and you and will not be shared with others without written consent. However, there are legal exceptions that I want you to be informed of at the beginning of therapy.

These exceptions to confidentiality are as follows:

- 1. The client authorizes a release of information with a signature;
 - 2. Any official review of services provided (as required by insurance).
 - 3. The client's records are subpoenaed for a legal matter;
 - 4. The client presents as a physical danger to self (e.g., suicide) and/or others (e.g., homicide, assault, physical harm)*;
 - 5. Child or elder abuse (e.g., physical, mental, emotional, sexual) and/or neglect is suspected*; or
 - 6. The client reports sexual exploitation by a therapist*.
- B. If you are a minor, you do not have the same "right" to confidentiality that an adult does. However, I view confidentiality as a must for a healthy psychotherapy relationship. Therefore, I will discuss with you and your parent/guardian the limits of confidentiality regarding our therapy together.
 - C. It is important to note that cell phones and email may not be secure. If you use a cell phone or email to communicate with me, please be aware that I cannot ensure confidentiality.
 - D. Further, I participate in team consultation. Therapy sessions may be discussed with other clinicians when deemed appropriate; however, in this case no identifying information will be used, only circumstances involved in the case will be discussed.

*In the case of items V. (A)(4, 5, and 6) listed above Kentucky law mandates that mental health professionals may need to report these situations to the appropriate persons and/or agencies so that protective measures can be taken.

Professional Fees

<u>Type of Service</u>	<u>Description</u>	<u>Insurance Fee</u>	<u>Self-pay</u>
Initial Evaluation	60 minute interview	\$200	\$200
Psychotherapy	45-55 minute session for Ind. or Family	\$175	\$175
School Observation or School Meeting	per school visit (typically not covered by insurance)	N/A	\$200/hr
Phone Consultation	for calls exceeding 15 minutes in length	N/A	\$30/15 min.

Special Fees

Late cancellation of therapy session (appointments canceled with less than 24 hours notice)	N/A	\$30
Missed appointment Without notification to office	N/A	\$60
Special Letter Writing & Report Review (allow 5 business days to complete) (with a minimum of \$25)	N/A	\$100/hr
Returned Check (per occurrence)	N/A	\$30
Notarized copy of chart	N/A	\$75
Legal Fees (giving a deposition or attending a legal meeting/proceeding) (an \$800 deposit is required in advance)	N/A	\$400/hr

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW CLINICAL INFORMATION ABOUT YOU AS A CLIENT OF MARIA ALLEN-JENKINS, Psy.D., PLLC MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy and our legal duty:

Your information is personal and confidential. We are committed to protecting your information and are required by applicable federal and state law to keep it private. In conducting our business at Maria Allen-Jenkins, Psy.D., PLLC, we are required to create and retain records of the care and services you receive at this office, as well as other offices, if it becomes available to us. We are 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 this notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this notice at any time provides such changes are permitted by applicable law. The new terms of our notice will be effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available to you. Any revised notice will contain the effective date.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health services.

How this office may use and disclose your protected health information

Your protected health information may be used and disclosed to your physicians, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice, and any other use required by law only with your written consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Additionally, we may disclose your protected health information to others that may assist in your care, such as your spouse,

parents, or legal guardians, or others only in emergent situations that require legal exceptions to confidentiality.

Payment: We may use and disclose your protected health information in order to bill and collect payment from you, an insurance company or a third party for the services and treatments you may receive from us. For example, we may contact your health insurance carrier to certify that you are eligible for benefits (and for what range of benefits). We may also disclose relevant protected health information to your health plan to obtain approval for a hospitalization admission, if necessary.

Release of information to Family/Friends: We may use and disclose your protected health information to notify, or assist in the notification of (including identifying or locating) a family member or another person responsible for your care, or your location your general condition, or death. In the event of incapacity, illness, or emergency circumstances, we will disclose only relevant health information to the person who assists in your healthcare.

Required by law: We may use or disclose your protected health information without your consent or authorization in certain situations. These situations include: Required by Law; Public Health; Communicable Disease; Health Oversight; Abuse or Neglect; Food and Drug Administration; Legal Proceedings; Law Enforcement: Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military or National Security; Workers Compensation: Inmates, Required Uses and Disclosure. The use of disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Serious threats to health of safety: We may use and disclose your protected health information when necessary to reduce or prevent a serious threat to health and safety to you, another individual or the public. Under these circumstances, we will only make disclosure to a person or organization able to help prevent the threat.

Your Rights Regarding Your Protected Health Information

Access: You have the right to look at or obtain copies of your health information, with limited exceptions. You must submit a request in writing to obtain access to your health information. You are allowed one copy free of charge. After your one free copy you will be charged \$0.25 per page for additional copies of your health information. We may deny your request to inspect the copy in certain very limited circumstances. Under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

Amendment: You have the right to request that we amend your health information if you believe it to be incorrect or incomplete for as long as the information is kept by this office. Your request must be in writing and it must explain why the information should be amended. We may deny the request if you ask us to amend information that is in our opinion: (a) accurate and

complete; (b) not part of the health information kept by this office; (c) not part of the health information which you would be permitted to inspect and copy; or (d) not created by our practice. If we deny your request for an amendment you have the right to file a statement of disagreement with us and we will prepare and provide you with a copy of the rebuttal.

Confidential Communication: You have the right to request that we communicate with you about health and related issues in a particular manner or location. For example, you may request that we contact you at home rather than work, and leave a message on voice mail or in person in reference to appointment reminders, insurance items, and clinical care. You must make this request in writing, specifying the method of contact or location desired. We will accommodate all reasonable requests.

Restrictions: You have the right to request that we place additional restrictions on our use of disclosure or your protected health information. You may request that it not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and must state the specific restriction that you may request. If we believe it is in your best interest to permit us and disclosure or your protected health information, your protected health information will not be restricted. If we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

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, and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you. You must submit your request in writing and specify a time period, which may not be longer than two-(2) years from the date of the disclosure.

Your Authorization: You have the right to provide the office with a written authorization to use and disclose your protected health information for purposes other than identified by this Notice of Privacy Practices. With written authorization we may use and disclose your information to anyone for any purpose. Any authorization you provide to us may be revoked any time, in writing. Your revocation will not affect any use or disclosures permitted by our authorization while it was in effect.

Complaints: If you believe your privacy rights have been violated you may voice your concern to us or to the Secretary of the Department of Health and Human Services. Please file your complaint in writing and it will be addressed at your next scheduled session. You will not be penalized for filing a complaint.