LAKESIDE COUNSELING, LLC

NOTICE OF POLICIES, PRIVACY PRACTICES, CLIENT RIGHTS, AND CLIENT RESPONSIBILITIES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS INFORMATION CAREFULLY.

Updated: 10/13/2024

Protected Health Information

In accordance with all local, state, federal, and ethical standards for privacy and protection (including HIPAA), Patrick Murphy, MS, LPC (hereafter referred to as Provider) of Lakeside Counseling, LLC (hereafter referred to as Practice) acknowledges the critical importance of Protected Health Information (PHI) and strives to ensure the confidentiality of the health information of all his clients. PHI is any data, including demographic information, that can reasonably be used to identify a person.

In compliance with the current standards, Therapist acts with changes made within the fields of mental health, counseling, and social work, and may change or amend this notice at any time for the purpose of remaining in compliance. If changes to this notice are made, reasonable efforts will be taken to ensure that clients receive and sign a copy of the new Notice. Please note that this Notice, as well as any signed revision of this notice, will apply to all PHI regardless of when it was originally created or received. A copy of my Notice of Privacy Practices can be requested at any time and can be provided in paper or electronic formats.

Use and Disclosure of Protected Health Information

Provider will not sell your PHI or disclose your PHI to any entity that may try to sell you products or services. In most cases, Provider will require written authorization to use, release, or disclose your personal health information. You may request disclosure of your PHI to another party for any purpose at any time with a written authorization. This authorization is available, on request, from Provider. The following list encompasses the legally and ethically recognized exceptions to my disclosure policy:

- For Treatment and Health Care Operations: To assure quality of care, we may utilize health information about you to provide you with treatment, services, or recommendations. (Example: Your PHI could be used to review our treatment and services, evaluate staff performance, or to discuss treatment alternatives or other health-related benefits and services with you as applicable.) In the event that your PHI is utilized for the purposes of professional consultation, reasonable efforts will be made to limit the PHI disclosed during the consultation.

- For Purposes of Conducting Business: Some PHI is required for the purposes of conducting business, such as disclosure of information (including demographics and

diagnoses) to your insurance company or to our third-party billing service. This also includes collections agencies, when applicable.

- When Required by Law: We will use and disclose your PHI if required to do so by law and for the purposes of mandated reporting. For more information regarding Michigan's rules regarding mandated reporting, please visit https://tinyurl.com/yd6h3jqr.

    - This includes:
      For the purposes of reporting child or adult abuse or neglect;
      For the purposes of reporting domestic violence;
      In the event that a client poses a threat of danger to self or others;
      In the event that a client discloses a threat of danger made to self or others;
      When served with a court-order or subpoena, specific to the PHI ordered;
      When disclosure of specific PHI could save a client's life (i.e. disclosure of allergies during an allergic reaction, or of known
      prescription medications if asked by an EMT during an life-or-death emergency situation);
      In compliance with workers' compensation laws.
      When required by the Secretary of the Department of Health and Human Services and/or applicable state or federal
      regulatory agencies.

<u>Individual Rights and Responsibilities</u>
As a client, you have the rights and responsibilities regarding your PHI outlined below. To exercise these rights, a written request must be provided to Provider and reviewed by Provider. This request should include how and where (if applicable) you prefer to be contacted. Provider will honor all reasonable requests made in this manner.

You have the right to:

- Access, Inspect, and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Therapist may deny your personal request to inspect portions of your records in limited and reasonable circumstances (i.e., a non-critical request for psychotherapy notes when viewing those notes without appropriate context and understanding could undermine the therapeutic relationship*). Records can be requested for personal use in paper or electronic formats. For an electronic copy of your records, a flash drive must also be included with your request. Please note that electronic copies of your records are more vulnerable to security breaches, and Therapist cannot guarantee the safety and confidentiality of your information after transfer. Pursuant to Medical Records Access Act, Public Act 47 of 2004, MCL §

333.26269, Updated for 2018, Provider reserves the right to charge a fee for the costs of copying, mailing, or other supplies associated with your request for this information.

*Note: If you wish to receive a copy of your records, we strongly encourage you to review them with Provider so that you can fully understand their contents. If your request for access is denied, Provider will explain the reason for the decision to deny and discuss with you your options for further review.

- Accounting of Disclosures: You have the right to request a list of the disclosures PHCS has made of health information about you, such as disclosures made as required by law. This accounting requirement applies to disclosures made on or after April 1, 2018. Records of accounting cannot be made for dates occurring before April 1, 2018, or after the date of the request. Records can be requested in paper or electronic formats. Electronic copies of these records are subject to the same requirements and vulnerabilities as outlined in the Access, Inspect, and Copy section of this Notice. The first request made within a 12-month period will be provided for free. For additional requests in a 12-month period, Provider reserves the right to charge a fee for the cost of responding to these additional requests. A schedule of these fees can be provided on request.

- Request Restrictions: You have the right to request a restriction or limitation on the health information Provider uses or discloses about you for treatment, payment, health care operations, and/or to someone who is involved in your care or the payment for your care. Please note that Provider is not required to comply with your request, particularly if the request is made regarding uses and disclosures that can be legally and ethically be made without your consent. If an agreement is made to restrict disclosure of your information, Provider will comply with the request until such a time as the disclosure of your information becomes necessary for emergency treatment and/or as required by law (as applicable). You will be notified in any case that a restriction agreement must be terminated.

- Amendment: You have the right to request that Provider amends your PHI if you feel it is incorrect or incomplete and may do so for as long as the information is kept. Your request must provide a reason that supports the need for amendment. Provider may deny your request for amendment if the request is not made in writing or does not include an adequate reason to support the request. Additionally, Provider may deny your request if the information was not created by him, is not information he keeps in your records, is not information that you are normally permitted to inspect and/or copy, or any information that Provider deems to be accurate and complete. If he denies your request for amendment, you have the right to file a statement of disagreement with him. He may prepare a rebuttal to your statement, and you will be provided with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept with

your records and will be included with any future authorized requests for information pertaining to the appropriate portion of your record.

- Payment: Payments, including deductibles and co-payment/co-insurance, are due at the time of service. Payments can be made by credit/debit card only. A receipt for payment will be made available upon request. Clients are responsible for contacting their insurance company to obtain authorizations, co-pays, deductibles, and benefit period information. All co-pays and deductibles are due the day of service via the card stored on file.

- High Balances: While Provider understands that financial issues may arise during therapy, he is unable to continue providing services in absence of a payment plan or arrangement once your balance reaches $100. It is your responsibility to ensure that the appropriate payment method is on file for each session. It is your responsibility to request a payment arrangement. If a payment arrangement is created and not adhered to AND/OR your balance reaches $100, and your card continues to decline, Therapist reserves the right to remove you from the schedule until the balance is fulfilled. You will be provided with referrals should you decide to seek treatment elsewhere. If the card on file is declined services will be suspended until the balance is paid.

THIS PROVIDER ACCEPTS AMERICAN EXPRESS, VISA, MASTERCARD, AND DISCOVER.

Individual Sessions are sessions in which the client participates with the therapist without significant contribution by any persons brought into therapy by the client. The third party cannot be present and participate for more than 26 minutes if it is to be considered an individual session.

Individual Session, 16-37 minutes: $100/session
Individual Session, 38-52 minutes: $125/session
Individual Session, 53 minutes or more: $150/session
Couples Session, $125/session flat rate
Family Session, $200/session flat rate

Sliding scale payments are available if the client is experiencing financial hardship; proof of hardship is required to access said sliding scale.

Couples Sessions are sessions in which both the primary client and their romantic partner attend and participate in; Family Sessions are sessions in which both a minimum of one parent and one child, adult or minor, are involved. Sessions are charged at a flat rate of $125/session for couples and $200/session for family. It is important to note that releases of information are required to be able to share any information connected with any individual session with the primary client’s romantic partner or adult child. If the primary client is a minor, no release of

information is required to be able to share information with a parent. Family sessions can be billed as such provided they last 26 minutes or more.

ADDITIONAL SERVICES AND ASSOCIATED FEES

Court Appearances are defined as this therapist appearing in court, all preparation times, driving times and mileage, contact with any involved attorney (provided a release of information has been signed and received), depositions, client records, and any other time devoted to the preparation and giving of testimony. The fee for a Court Appearance is $2000 for the first 4 hours of said engagement, with $500/hour after the first 4 hours have been reached. This fee must be paid in full prior to the court date; if a Client is under financial hardship, a payment plan may be created but only if proof of said hardship is furnished.

Medical Records Requests are requests for your records. These include assessments, dates of service with diagnoses, and discharge summaries. Please note that psychotherapy notes are excluded per the Health Information Portability and Accountability Act of 1996 (HIPAA). The fee is $50/request.

Report Writing consists of any and all letters written for a legal purpose, whether it is school, worker's compensation, disability, employers, and any other recommendation letter. The fee is $200.

Verification Letters are letters written specifically at the Client's written request, addressed "To Whom it Concerns", meant only to verify that the Client is actively receiving services, and then provided to the Client. The Client is the sole responsible party for the dissemination of the letter and/or its contents. The fee is $10/letter.

Cancellation/No-Show Policy: Sessions can be cancelled or rescheduled up to 24 hours prior to their start time without penalty. If you are unable to attend your appointment and do not notify this therapist within 24 hours of the scheduled appointment time, you will be charged a $20 late cancellation fee. Such charges are not billable to insurance and are due prior to the next appointment. Please note that this fee cannot be charged to clients with Medicaid.

Services NOT PROVIDED by this Practice: Diagnostic (such as intensive ADHD or ASD) and/or Evaluative (for legal competency or guardianship) Psychological Testing, Medication Management, and Reconciliation Therapy related to parental custody are expressly NOT offered at this practice. Screenings and evaluations for SSI, SSDI, Short-Term Disability, FMLA, etc. are NOT offered. Appropriate referrals for these evaluations will be provided upon request. As this Provider does not train therapy or emotional support animals, this Provider cannot write letters to landlords, transportation providers, employers, or other interested parties regarding said animals. This Provider does not conduct formal threat assessments for third parties, whether court, school, business, or other entity. If a client makes statements in session which rise to the level of Duty to Warn, that is, makes statements which indicate a direct immediate threat to any third party (as defined by specificity and feasibility in accordance with MCL 330.1946), all applicable Duty to Warn/Mandatory Reporting laws will be followed promptly and to the letter.

Termination of Services Policy: Therapy services provided to Client may be terminated due to 3 missed sessions within a calendar year; non-payment for services rendered; any and all

direct and/or imminent harm to yourself; and/or any threat of direct and/or imminent harm made by yourself towards other persons or animals, Provider is required by law to break confidentiality and take whatever steps at his disposal to prevent the indicated danger. In accordance with state law, Provider may only provide Telehealth services to you if you report you are within the physical boundaries of States in which Provider is licensed at the time of service. Any and all legal liability for falsely reporting or representing your location resides with you. Currently, Provider is licensed in the State of Michigan.

Emergencies: In the event of a mental health emergency, please call 911 or get to the nearest emergency room for crisis screening/evaluation. Provider may not be available at the time of your emergency but will make appropriate efforts to establish contact with you or your authorized representative as soon as practicable.

For all questions, comments, and concerns, please contact Provider at (810) 356-7594, or through the online platform in which you receive services from Provider. Please note it may take up to 48 hours to process and respond to communications.

In the case of a complaint, clients are encouraged to contact Provider for resolution. If Provider is unable to successfully resolve your complaint with you, you may also submit a written complaint to:

Michigan Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing Investigation & Inspections Division
PO Box 30670
Lansing MI 48909
(517) 373-9196

I, the undersigned, have received and agree to abide by all the policies, practices, rights, and responsibilities as indicated above. I understand that the dissemination of any personality identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

I also understand that there are several forms of psychotherapy treatment modalities that have been found to be effective in treating a wide range of mental health disorders, personal and relational issues; including Telehealth. However, there is no guarantee that all treatment will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to Telehealth, including but not limited to; the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons.

In addition, I understand that Telehealth treatment is different from in-person therapy and that

if my Provider believes I would be better served by another form of psychotherapy services, such as in-person treatment, I will be referred to a therapist in my geographic area, or to Peace & Harmony Counseling Services, LLC that can provide such services.

Finally, I agree that in case of an emergency I will contact 911, visit the nearest emergency room and then contact my Provider to bring him/her up to speed.

I have read and understand the information provided above. I have the right to discuss any of this information with my Provider and to have any questions I may have regarding my treatment answered to my satisfaction. I understand that I can withdraw my consent to Telehealth communication by providing written notification to Therapist.

Printed Name:____

Signature:____ Date: _____________________

Parent (in case of Minor)'s Name:____

Signature:____ Date: _____________________