Fraser Vaselakos & Associates 12627 West 143rd Street ~ Homer Glen, Illinois 60941

Fraser Vaselakos & Associates, PC HIPPA Form

As licensed psychologists, social workers and licensed clinical professional counselors we are required to present patients with the following form for review and signature. Our strict and confidential office practices preceded and follow current governmental policies regarding how a patient's health information is utilized.

TREATMENT: Therapy works best when the patient is open to exploring new ways of coping, is active in the process, honest and forthcoming, willing to ask questions, and sharing any concerns with the therapist, particularly when a patient feels frustrated or is at a therapeutic impasse. "Short or long" term therapy is a meaningless term. The one or two hours a week a patient may spend in therapy pales in comparison to the many, many hours, weeks, and even years of pain a patient has endured prior to entering therapy. Comprehensive treatment means giving the patient reasonable time to heal and make permanent changes in his/her life. Fraser Vaselakos & Associates strives to do Comprehensive treatment resulting in permanent life changes. Therapy continues until the patient and/or therapist determines to terminate treatment. Generally this decision is reached mutually by both the patient and therapist.

CONSULTATION: Therapists in our practice may consult with another psychologist, physician, or health care provider about a patient's treatment. A patient will be advised if his/her therapist determines consultation on the patient's case is necessary and beneficial for healing treatment. Consultation will only happen with the patient's approval. If a case consultation is required it will occur according to our professional code of ethics mandating keeping information confidential.

EMERGENCIES: Patients may call their therapist and leave a message at any time and that therapist will check messages and make every effort to return the patient's call by the end of the next business day, with the exception of weekends, vacation times and holidays. When a patient's therapist is out of the office, unavailable or on vacation, another therapist may cover phone calls. When a patient calls his/her therapist the patient should leave times and dates that are best for therapist to reach patient, and therapist will try, within the confines of their schedule, to call during those times.. If a patient cannot reach his/her therapist, and the patient feels he/she cannot wait for a return phone call, the patient should call his/her family physician, psychiatrist, or go to the nearest hospital emergency room. If a patient experiences an emergency during the night or anytime a therapist is not available, that patient should contact a hotline, dial 911 or go immediately to their local hospital emergency room.

EMAIL/TEXTING: Patients can contact Fraser Vaselakos & Associates, PC by email at info@fvclinical.com. To text one's therapist directly requires one's therapist to provide and approve that means of communication. Please note that email and texting are not a secure form of communication, and therefore a patient should not discuss sensitive matters, send emergency messages or seek clinical advice through email or texting. If a patient is experiencing an emergency, she/he should call 911 or go to the nearest hospital emergency room.

SOCIAL MEDIA/DIGITAL TECHNOLOGY: Social media is publicly visible, and therefore friending, following, or "liking" your therapist or your therapist "liking" you would expose your association with that therapist breaching patient privacy. To protect patient privacy it is Fraser Vaselakos & Associates' policy not to friend, follow, or like any patient's Social Media Accounts (i.e. Facebook, Instagram, Twitter).

CONFIDENTIALITY: Fraser Vaselakos & Associates will use and communicate patient health information only for the purposes of providing treatment, obtaining payment, and conducting health care operations. Patient health information will not be used for other purposes unless we have been asked for and been voluntarily given patient's written permission. We will use patient's health information within our office to provide patient with the best therapeutic care possible. This may include, but not limited to, administrative and clinical office procedures designed to optimize scheduling and billing. We may include patient's health information with an invoice used to collect payment for treatment received in our offices. We may do this with insurance forms filed for a patient in the mail or sent electronically. We only have control over information in our office and have no control over patient information once it is sent to the patient's designated insurance company or location (home, office) provided by the patient during registration. All information disclosed within sessions and the records pertaining to those sessions are confidential and may not be revealed to anyone without the patient's written permission, except where disclosure is

required by law. Licensed Clinical Psychologists, Licensed Clinical Social Workers and Licensed Clinical Professional Counselors are mandated by law to break confidentiality if a patient reveals in a session that she/he is at danger to self or others and/or where there is a suspicion of child abuse, dependent abuse, elder abuse or neglect.

PAYMENT AND INSURANCE REIMBURSEMENT: All patients must have a current credit card on file. With a patient's permission current session balances can be charged on patient's credit card. In addition, patient's credit card will be used to settle account balances that are over 60 days. Our office will contact any patient with a 30 day overdue balance to settle that balance and/or to set up payment plans.

FINANACIAL RESPONSIBILTY: I _____(patient's name or guardian name) understand that I am financially responsible for this therapeutic treatment and that payment is expected either at the time of service or within 30 days upon receiving a monthly statement. I understand that the therapist is willing to assist me in submitting claims to my insurance company, but that I am ultimately responsible for any portion of the fees not reimbursed or covered by my health insurance. Overdue accounts may be subjected to 1.5% per month or 18% annual interest rate charged and computed on the unpaid balance. All efforts will be made to collect due payment, but accounts will be sent into collection if the office does not receive payment from patient in a timely fashion.

CANCELLATION: When a patient makes an appointment, we are reserving that block of session time in the therapist's schedule that is no longer available to any other patient. If a patient needs to change a scheduled appointment we will make every effort to do so, but please know that any missed or canceled appointments are charged at the rate of a normal office visit, unless that appointment time is filled from our patient waiting list. Of course, illness and emergencies are exceptions to this policy. All sessions will be charged for in full and insurance companies do not cover session that were scheduled, but not kept. Missed appointment fees are charged when appointments are missed with no cancellation call or when appointment is cancelled less than 24 hours ahead of time.

MINORS IN THERAPY: The parent/guardian who brings a minor child in for treatment is responsible for the bill. They are responsible to pay the balance for the minor child they brought in for services, rather than expecting the other parent, or anyone else, to pay the balance. If the patient is a dependent adult, another responsible party must guarantee payment, as in the case of a minor child. Terms for minors are the same as those listed under the Financial Responsibility section of this HIPPA Form.

ACKNOWLEDGEMENT AND AGREEMENT: By signing this form, I am consenting to Fraser, Vaselakos & Associates use of my health information to carry out treatment and obtain payment for services rendered. In consideration of therapeutic treatment to be received, I do hereby assign and transfer to Fraser Vaselakos & Associates my rights and interest in my health insurance policies for claims that are filed on my behalf to the extent benefits are available. I have read the above information and thoroughly acknowledge, understand and agree to all of the above information.

Patient Printed Name _____

Guardian Printed Name_____

_____Self_____Guardian _____for Patient _____

Patient/Guardian Signature_____Date_____

Witness_____Date_____