CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full fee is charged for missed appointments or no show cancellations with less than a 24 hour notice unless due to illness or an emergency**.** A bill will be mailed directly to all clients who do not show up for or cancel an appointment.

CHECK RETURN POLICY

If a check is returned for insufficient funds, you will be charged the check amount plus a return check fee of $35.00

PAYMENT POLICY

Payment for treatment is expected at the end of each session. Payments, which are delinquent by more than 90 days, may be referred to a collection agency at the expense of the client.

*Please remember, if your insurance changes, let us know immediately. Regardless of the outcome of insurance reimbursement, all payments are to be paid in full to Dr. Post. As a service, we are happy to assist in tracking insurance verifications initially and ongoing authorizations as well other payment issues, however, you are ultimately responsible for payment in full.

I have read and understand the above conditions and financial policy; I am responsible for complete payment, regardless of insurance outcomes, and will adhere to the conditions set forth on this document.

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Today's Date

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patients Name: _____

Date of Birth: _____

I understand that, under The Health Insurance Portability Accountability of 1996, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read and understood The Notice of Privacy Practice.

Dr. Cynthia L. Post Ph.D., reserves the right to change the terms of the Notice of Privacy Practice. I understand that I will be provided a current Notice of Privacy Practice on request and a copy will be displayed in the office waiting room.

Signature:

_____

Parent/Guardian (if applicable):

_____

Date:

_____

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 CAREFULLY.

Safeguarding Your Protected Health Information

Dr. Post is committed to protecting your health information. In order to provide treatment or to pay for your healthcare, she will ask for certain health information and that health information will be put into your record. The record usually contains your symptoms, examination and test results, diagnoses, and treatment. That information may be used for a variety of purposes. Dr. Post is required to follow the privacy practices described in this Notice.

Uses and Disclosures Relating to Payment

To obtain payment: Dr. Post may use and share your health information in order to bill and collect payment for your health care services and to determine your eligibility to participate in her services. For example, your health care provider may receive claims for payment of services provided to you.

You have a Right to:

Request restrictions: You have a right to request a restriction or limitation on the health information I use or disclose about you. I will accommodate your request if possible, but am not legally required to agree to the requested restriction. If I agree to a restriction, I will follow it except in emergency situations.

Request Confidential Communications: You have the right to ask that I send you information at an alternative address or by alternative means. I must agree to your request as long as it is reasonably easy for me to do so.

Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket: You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

Right to Be Notified if There is a Breach of Your Unsecured PHI: You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised**.**

Right to Opt out of Fundraising Communications: You have a right to decide that you would not like to be included in fundraising communications that I may send out.

Additions in Compliance with the HIPAA Final Rule of 2013:

I will also obtain an authorization from you before using or disclosing:
· PHI in a way that is not described in this Notice.
· Psychotherapy notes
· PHI for marketing purposes
· PHI in a way that is considered a sale of PHI

I do not have to obtain authorization from you:
· When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.