WILLIAMSBURG
THERAPY GROUP

A Mental Health Collective

CANCELLATION AND FEE POLICIES

This policy statement has been prepared to prevent misunderstandings regarding your attendance and payment for sessions and consultations conducted by Williamsburg Therapy Group and to insure the continuity of your treatment.

APPOINTMENTS

I understand that once I begin treatment with Williamsburg Therapy Group , I will have a specific time reserved to meet with my clinician, typically once a week for 45/50 minutes. I am responsible for attending my session on time and understand that if I appear late for a session it unfortunately means that I will lose time from that session. In addition, if there are excessive absences in your assigned appointment slot; your doctor reserves the right to offer that appointment slot to another client.

FEE

I understand that Williamsburg Therapy Group and I have agreed on a starting fee for treatment, as indicated in the appointment information. I also understand that Williamsburg Therapy Group has the right to increase my session fee at any time by giving me verbal and/or written notice at least 4 weeks in advance of the fee increase.

PAYMENT

I understand that payment is due in full at the end of each session. If I fail to pay for two or more consecutive sessions, Williamsburg Therapy Group has the right to stop treatment with me and refer me to another appropriate treatment provider. I will pay by cash, check or credit card (MasterCard, Amex, or Visa).

CANCELLATION POLICY

I understand that a full fee is charged for cancellation for any reason, which includes, but is not exclusive to: illnesses, medical emergencies, child care conflicts, travel delays, and job demands. If I have to miss a session, I will notify my provider at Williamsburg Therapy Group at least **48** hours in advance via e-mail at contact@williamsburgtherapygroup.com in order to avoid incurring the charge of my session fee. If I do not give 48 hours advanced notice, I understand that I will be charged for a full session.

I have read and reviewed Williamsburg Therapy Group's cancellation and fee policies and agree to abide by them.

62 Grand Street Brooklyn New York 11249
(347) 765 - 0904
contact@williamsburgtherapygroup.com
williamsburgtherapygroup.com

WILLIAMSBURG
THERAPY GROUP
A Mental Health Collective

HIPPA NEW YORK NOTICE FORM/Consent to Treatment

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to protected health information, which is demographic and health information that could identify you.

- "Treatment, Payment and Health Care Operations"
    - Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
    - Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
    - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "Use" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

- "Disclosure" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

62 Grand Street Brooklyn New York 11249
(347) 765 - 0904
contact@williamsburgtherapygroup.com
williamsburgtherapygroup.com

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization, or release of information, from you before releasing this information.

You may revoke all such authorizations of PHI at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If, in my professional capacity, a child comes before me which I have reasonable cause to suspect is an abused or maltreated child, or I have reasonable cause to suspect a child is abused or maltreated where the parent, guardian, custodian or other person legally responsible for such child comes before me in my professional or official capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child, I must report such abuse or maltreatment to the statewide central register of child abuse and maltreatment, or the local child protective services agency.

- Health Oversight: If there is an inquiry or complaint about my professional conduct to the New York State Board for Psychology, I must furnish to the New York Commissioner of Education, your confidential mental health records relevant to this inquiry.

- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without your written authorization, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I must inform you in advance if this is the case.

- Serious Threat to Health or Safety: I may disclose your confidential information to protect you or others from a serious threat of harm by you.

- Worker's Compensation: If you file a worker's compensation claim, and I am treating you for the issues involved with that complaint, then I must furnish to the chairman of the Worker's Compensation Board records which contain information regarding your psychological condition and treatment.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

- Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

- Right to a Paper Copy: You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will provide you with an updated copy if you are still in therapy with me. If we have ended therapy, you may request an updated copy to be sent to you by mail.

V. Questions and Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please contact your clinician at Williamsburg Therapy Group at (347) 765-0904 or contact@williamsburgtherapygroup.com about your concerns. If you do not feel comfortable doing this, you may call The New York State Psychology Licensing Board at 1-800-442-8106 or send an email to conduct@mail.nysed.gov with your questions or a complaint. You may also address your complaints to the Secretary of the U.S. Department of Health and Human Services by obtaining their contact information on their website at www.hhs.gov/ocr/hipaa.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on January 01, 2019.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by providing you with a paper copy at our next session from the date of revision. If you are no longer in therapy, I will provide a revised notice only at your written request.

VII. Consent for Treatment

I have read and understood this policy statement. I accept, understand, and agree to abide by the contents and terms of this agreement and further, consent to participate in this intake evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

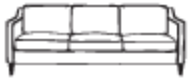
WILLIAMSBURG
THERAPY GROUP

A Mental Health Collective

DEBIT/CREDIT CARD AUTHORIZATION FORM

I would like to put my card on file to pay regularly (e.g. weekly, bimonthly) for my sessions and to be used only in the event that I delay payment by 7 or more days from the date of service or if I cancel outside the 48 hour cancellation policy.

I authorize Williamsburg Therapy Group to charge the debit or credit card listed above in accordance with the terms of the cancellation and fee policies agreement.



62 Grand Street Brooklyn New York 11249
(347) 765 - 0904
contact@williamsburgtherapygroup.com
williamsburgtherapygroup.com