



3625 Chapel Road, Newtown Square, PA 19073 TEL: 484-427-4673

## PRACTICE GUIDELINES

*Sage Counseling, LLC is pleased that you have chosen us and we are committed to providing you with affordable quality services. Please read the following practice guidelines to help insure you understand our office policies:*

### APPOINTMENTS AND FEES

- Sessions are scheduled on the hour and go until 10 minutes before the end of the hour.
- Payment is due at the TIME of each session. Payment is accepted in the form of check, cash (exact change only), or credit card (Visa or MasterCard only). Checks should be made payable to Sage Counseling, LLC. There is a \$35 returned check fee for checks which do not clear.
- If you have Medicare, please bring your card to the first appointment. If there is any change to your insurance status, please notify the therapist.
- You may discuss and questions you have regarding payment and/or insurance with your therapist.
- Phone calls which extend beyond 15 minutes will be billed at  $\frac{1}{4}$  of the session rate for each 15 minute increment. Accepting such calls is at the sole discretion of the therapist.
- Sessions in which clients arrive late or leave early will still be billed for the full hourly rate.

### CANCELLATION OF APPOINTMENTS

- All cancellations must be made at least 24 hours from the start of the scheduled session. Clients agree to pay in full for sessions which are cancelled within 24 hours of the scheduled session time.
- Clients may cancel by leaving a voicemail in the therapist's Sage Counseling Inbox at 484-427-4673.
- Requested sessions are not booked until confirmed by the therapist.
- The therapist has the discretion to not bill a client for a session which is canceled within 24 hours of the appointment due to an emergency (ex: illness, accident, hospitalization) or inclement weather.
- Clients who miss appointments without cancelling will need to pay the full cost of the missed appointment at the next session.

### EMERGENCIES

- If there is an emergency please, please call 911 and/or go to the nearest hospital emergency room. After the emergency is over, please call your therapist.

- On occasion, the Therapist will take vacation time. Other members of the practice will be on-call for client needs during that time.

**CONFIDENTIALITY**

- Sage Counseling, LLC will not release any records without your prior consent and a signed Release of Information form indicating to whom and what information may be released.
- Sage Counseling therapists are mandated reporters. Therefore, under certain circumstances we may have to release information without your prior consent.
- If you have any questions, please discuss with your therapist.

**YOUR RIGHTS AND RESPONSIBILITIES**

- Sage Counseling, LLC will provide a copy of the HIPAA regulations.
- Sage Counseling, LLC will provide a copy of its "List of Rights and Responsibilities"
- You will be asked to sign a form indicating that you have received this information.

**MISCELLANEOUS**

- All clients agree by signing this document that they are not a party to a lawsuit or court action in which Sage Counseling, LCC will be called to provide testimony. Such examples include divorce or custody proceedings.
- Counselors are willing to discuss providing a written report for court-ordered DUI counseling.

My signature below indicates that I have read and understand the practice guidelines of Sage Counseling, LLC. If I have any questions or concerns, I agree to speak with my therapist.

\_\_\_\_\_  
Client or Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

Copy offered:    Yes    No



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**RIGHTS AND RESPONSIBILITIES**

<b>YOU HAVE A RIGHT TO:</b>	<b>YOU HAVE A RESPONSIBILITY TO:</b>
Be treated with dignity and respect	Treat those giving care with dignity and respect.
Fair treatment regardless of race, religion, gender, ethnicity, age, disability or source of payment	Give providers true and accurate information they need so they can deliver the best possible care.
Have their treatment and other patient information kept private. Only where permitted by law, may records be released without patient's permission.	Follow the treatment plan and/or take medication.
Know about treatment choices, regardless of cost of coverage by the patient's benefit plan.	Tell their provider and primary care physician about medication changes including medication changes given by others.
Share in developing their plan of care.	Arrive for appointments on time or call to cancel the appointment at least 24 hours prior to the scheduled appointment.
A clear explanation of their condition and treatment options.	Avoid actions or threats that endanger the lives, health or social wellbeing of the Practice Group employees, providers or other clients.
To be told the consequences of refusing treatment or not complying with prescribed treatment.	Pay all necessary fees at the time of the appointment unless they have made alternative arrangement with the Practice providers.
To files a grievance should a dispute arise over treatment or claims	Address any concerns regarding services or quality of care to the Practice Provider.
Information about clinical guidelines used in providing and managing their care.	
Ask the provider about their work history and training.	
Request certain preferences in a provider.	
To have sufficient information to be able to give informed consent to treatment except in emergencies.	

My signature below indicated that I have read and understand my rights and responsibilities.

\_\_\_\_\_  
Client's or guardian's Signature

\_\_\_\_\_  
Date

Copy offered:    Yes    No



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## Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of the Notice of Privacy Practices under the Health Insurance Portability and Accountability Act.

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Client's Signature

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Date

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Client's Name (Print)

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Guardian's Signature

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Date

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Witness's Signature

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Date

**Notice of Privacy Practices  
(Federal Health Insurance and Portability Act)**

**1. THIS NOTICE<sup>1</sup> DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.** If you have any questions about this Notice or want additional information, please Call: 484-427-4673

**2. Purpose.** We are required by law to maintain the confidentiality and privacy of your protected health information. "Protected health information" is information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This Notice 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.<sup>2</sup> It also describes your rights to access and control your protected health information.

We are required to abide by the terms of this Notice, which is effective April 14, 2003. We reserve the right to change the terms of our Notice at any time as permitted by law. The new Notice will be effective for all protected health information that we maintain at that time and for information we receive in the future. We will post a current copy of the policy and will have copies of our current policy available each time you are here for health care services. We will also provide you with any revised Notice of Privacy Practices upon a request made by you via phone or in person.

**3. Uses and Disclosures of Protected Health Information for Treatment, Payment and/or Operations.**

The following categories describe different ways that we may use and disclose health information for treatment, payment and operations. At least one example is given for each category. Please be aware that not every possible use or disclosure is listed.

- A. Treatment:** We may use and disclose your protected health information to provide you with treatment and services and to coordinate your care. For example, we may disclose your protected health information to other agency clinical staff that are involved in your care as well as different departments of the agency in order to coordinate the various services you might need, such as prescriptions.<sup>3</sup>
- B. Payment:** Your protected health information may be used to obtain approval for and payment for services you receive. For example, we may confirm your eligibility with

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<sup>1</sup> This notice is based on the requirements of the federal Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 and 164.

<sup>2</sup> Please note that in many cases state law governing behavioral health treatment is stricter than HIPAA and provides even greater confidentiality protection for individuals. In those cases, we will follow state law thereby affording you the highest level of confidentiality.

<sup>3</sup> Although federal law would allow us to share confidential information with third parties who are also providing health care services to you, in compliance with state law we will not do so unless you provide written consent. 55 Pa. Code § 5100.32 (a)

insurance plans, governmental agencies, or Medicaid in order to obtain approval and/or payment of services.

- C. **Operations:** We may use or disclose your protected health information as necessary for our regular business activities such as health oversight, accreditation, licensing, and quality assurance. For example, members of the quality assurance team may use information in your health record to assess the care in your case in an effort to continually improve the quality and effectiveness of the healthcare services we provide.

As part of operations, we may contact you to provide appointment reminders.

We may share your protected health information with third party “business associates” that perform various activities for us involving protected health information (e.g., auditors, attorneys), but only when we have a written contract with the business associate that fully protects the privacy of your protected health information.

#### 4. Other Permitted and/or Required Uses and Disclosures

According to Federal Privacy Regulations, we may make the following uses and disclosures without obtaining consent or written authorization from you.

- A. Unless you object, under federal law we may disclose health information about you to a member of your family, a relative, a close friend or any other person you identify as involved in your care.<sup>4</sup>
- B. We may use or disclose your protected health information in an emergency situation when use and disclosure of the protected health information is necessary to prevent serious risk of bodily harm or death.<sup>5</sup>
- C. We may use or disclose your protected health information if and to the extent we are required by federal or state law. You will be notified, if required by law, of any such uses or disclosures.
- D. We may disclose to a court when ordered by the court.
- E. We may disclose to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, if we believe that you have been a victim of abuse, neglect or domestic violence, we may disclose your protected health information to the governmental entity or agency authorized to receive such information. Any disclosure of suspected abuse will be made consistent with the requirements of applicable Pennsylvania law.
- F. We may disclose to governmental agencies or private entities responsible for overseeing

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<sup>4</sup> We will follow applicable state law governing outpatient mental health and substance abuse treatment which prohibits this disclosure unless we obtain a written consent for release of information.

<sup>5</sup> Other Federal law (42 C.F.R 2.51; 2.12 (c) (5)) significantly limits this in the case of substance abuse treatment. Disclosure is only permitted to medical personnel to the extent necessary to handle a medical emergency or to law enforcement officials if the client has committed or threatened to commit a crime on program premises or against program personnel.

health care activities through audits, investigations, inspections and licensure. Oversight agencies include government and/or private agencies that oversee the health care system, government benefit programs, government regulatory programs and civil rights laws.

- G. **Required Uses and Disclosures:** Under federal law, we must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of 45 C.F.R. Part 164.308 et. seq.
- H. We may disclose for public health purposes such as notifying public health authorities regarding specific communicable diseases.<sup>6</sup>
- I. We may disclose to federal, state or local agencies engaged in disaster relief to the extent that such information is required to enable them to carry out their responsibilities in specific disaster situations.

**5. Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization.**

Other uses and disclosures of your protected health information not covered by this Notice or by laws that apply to us will be made only with your written authorization. You may revoke this authorization, at any time, in writing. If you revoke this authorization, we will no longer use or disclose your protected health information for the reasons covered by the authorization. However, we cannot undo any disclosures we have already made with the authorization and are required to retain our records of the care that we provided to you.

**6. Your Rights Regarding Your Protected Health Information.**

You have the following rights with respect to your protected health information:

- A. **You Have the Right to Request Restrictions:** You have the right to request a limitation or a restriction on the protected health information we use or disclose about you for treatment, payment or healthcare operations. We are not required to agree to a restriction that you may request. If we agree to the requested restriction, we may not use or disclose your protected health information in violation of the restriction unless it is needed to provide emergency treatment. You must make this request in writing to our Privacy Contact at the address listed below.
- B. **Right to Request Confidential Communication:** You have the right to request to receive confidential communications from us in a certain way or at an alternative location. For example, you can ask that we only contact you at home or by mail. We will accommodate reasonable requests. We may also condition this accommodation by asking you for specification of an alternative address or other method of contact. The request must be made in writing to our Privacy Contact at the address listed below specifying how or where you wish to be contacted.
- C. **Right to Inspect and Copy:** You have the right to inspect and obtain a copy of protected health information about you that we maintain. To inspect and/or obtain a copy of protected health information, you must submit your request in writing to our Privacy Contact. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other related costs.

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<sup>6</sup> We will abide by all provisions of the PA HIV-Related Information Act which imposes significant restrictions on the release of any information regarding HIV.

We may deny your request to inspect and copy in certain limited circumstances. Under federal law, for example, 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. Federal and State law permits us to deny your request to inspect and copy if the protected health information was obtained from someone under a promise of confidentiality. 55 Pa. Code § 5100.33(c)(2). State law also permits us to deny you access upon a clinical determination that disclosure of specific information would constitute a substantial detriment to treatment. 55 Pa. Code § 5100.33 (c)(1). Please contact our Privacy Contact if you have questions about access to your records.

**D. Right to Amend:** If you believe that health information we have about you is incorrect or incomplete, you may request that we amend it. Your request must be in writing, submitted to the address listed below, and must state the reason you are seeking an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us which will be made a part of your record. We may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal. Please contact our Privacy Contact if you have questions about amending your record.

**E. Right to Receive an Accounting of Disclosures:** You have the right to an accounting of disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You must submit your request in writing to the address listed at the end of this Notice. The right to receive this information is subject to certain exceptions, restrictions and limitations.

**F. Right to Receive a Copy:** You have a right to receive a copy of the Notice of Privacy Practices upon request.

## 7. Complaints.

If you believe we have violated your privacy rights, you may complain to us or to the Secretary of Health and Human Services. You may file a complaint with us by notifying our Privacy Contact. We will not retaliate against you for filing a complaint.

## 8. Contacting Privacy Officer.

You may contact our Privacy Contact by calling 484-427-4673 or in writing to the address below:

Sage Counseling llc  
3625 Chapel Road  
Newtown Square, PA 19073

Client Name: \_\_\_\_\_

Client ID: \_\_\_\_\_

**Sage Counseling, LLC**  
**Consent for Treatment**  
**Confidentiality of Information**

I voluntarily consent to receiving services as recommended by the professional(s) directly involved with my case and provided by the staff of Sage Counseling, LLC. I agree to participate in the information gathering process and to facilitate appropriate services. In the case of a child, both parents consent to their child receiving services as stated above.

I understand that all information pertaining to or arising out of services to any individual by any employee of Sage Counseling, LLC is confidential. No employee of Sage Counseling, LLC shall use or disclose to any person any information disclosed to them during the Assessment interview, except with the written consent of the individual. Before any information about any aspect of the assessment or service plan may be released to any third party, a written Consent to Release of Information must be obtained which is specific as to the nature of the information to be given, the person(s) to whom it will be given, the purpose of the communication and the dates for which the release is valid.

I understand that exceptions exist to the above statement of confidentiality whereby information may be released by Sage Counseling, LLC without my consent in accordance with applicable state and federal law. See 42 U.S.C. §290dd-22; 42 C.F.R. Part 2; 4 Pa Code §255.5; 28 Pa. Code §709.28; 71 Pa Stat. Ann §1690.108; 55 Pa Code §5100 *et seq.*; and 50 P.S. §7101 *et seq.* These include, as applicable:

1. Suspicion of child abuse (either current or past). All Sage Counseling, LLC employees are mandated reporters of suspected child abuse.
2. Indication of risk and/or intent to seriously harm self or others.
3. Under a valid court order.
4. Disclosure to medical personnel in a medical emergency.
5. Threat of commission of a crime at the program or against program staff.
6. Disclosure to qualified personnel for program audit and/or evaluation.

As a client of Sage Counseling, LLC, the above policy has been fully explained to me.

_____	_____	_____	_____
Client Signature	Date	Witness Signature	Date

I am the parent/guardian/legal representative (circle one) of the above named client and authorize and consent to the above stated services. Both parents must sign.

_____	_____
Authorized Signature	Date

Copy Offered:    Yes    No