Cynthia Kozmary, MFT, LADC
Marriage & Family Therapist
Licensed Alcohol & Drug Counselor
(dba-Vegas Counseling Center, LLC.)
702-567-4810

CONSENT TO TREATMENT

SERVICES: I understand that I have agreed to see Cynthia Kozmary. Cynthia holds her Masters Degree in the field of Marriage and Family Therapy and is licensed in the state of Nevada. It is the responsibility of the therapist to make recommendations that are in your best interest. If our services are not appropriate for your concerns, we may refer you to another professional. To ensure we provide you with the best possible service, consultation with other mental health care professionals may be necessary.

BENEFITS/RISKS: Counseling has been demonstrated to help many individuals. This is particularly true when you sincerely want to change and follow through with assignments or activities you and your counselor agree would be helpful for you. The primary risk of counseling is that the process may involve discussing problems or life events that may evoke unpleasant feelings. If this occurs, it is important to let the counselor know so that he or she can help you deal effectively with those concerns.

FEE SCHEDULE/CANCELLATION POLICY FOR CASH CLIENTS: Initial intake sessions are $125.00, weekly individual sessions are $100.00, and are due at time of appointment. A sliding scale will be provided as necessary. Appointments are 50-60 minutes in length. Please give 24 hours notice if you need to cancel your session, to avoid a full charge. Credit cards are accepted and will be charged by scheduling secretary.

CONFIDENTIALITY: All information conveyed in counseling sessions is kept strictly confidential, with following exceptions:

1) **In the event that there is a clear and imminent threat of harm toward yourself or another person**

a) **DUTY TO WARN AND PROTECT:**
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorizes. In cases in which the client disclosed or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

b) **ABUSE OF CHILDREN AND VULNERABLE ADULTS:**
If a client states or suggests that he or she is abusing a child or vulnerable adult or has recently abused a child or vulnerable adult, or a child or vulnerable adult is in danger of abuse, the mental health professional is required to report this information to the appropriate social services and/or legal authorities.

2) **MINORS/GUARDIANSHIP:**
Parents or legal guardians on non-emancipated minor clients have the right to access the clients' records.

3) **LEGAL CONSTRAINTS:** In the event of a court order requiring my testimony**,** under legal consultation, in response to a patient's raising the issue of mental health in lawsuit or when minors have limited rights of confidentiality.

4) **PROFESSIONAL CONSULTATION:** I may consult with other professionals regarding your case to ensure high-quality care. These professionals are required by law to keep confidentiality.

YOUR SIGNATURE ON THIS FORM IS YOUR ACKNOWLWDGEMENT OF THE ABOVE FACTS. PLEASE FEEL FREE TO DISCUSS ANY CONCERNS YOU MAY HAVE ON THESE OR OTHER ADMINISTRATIVE MATTERS WITH YOUR THERAPIST AS THEY ARISE.

I HAVE READ AND I UNDERSTAND THE CONTENTS OF THE ABOVE MATERIAL AND I VOLUNTARILY AGREE TO PARTICIPATE UNDER THESE CONDITIONS. AS PARENT OR GUADIAN, I ALSO GIVE PERMISSION FOR THE FOLLOWING MINOR CHILDREN TO PARTICIPATE:

Client Signature: _____

Date: _____

Provider Signature: _____

Date: _____

CLIENT QUESTIONNAIRE

Please fill out this biographical background form as completely as possible. All information is confidential as outlined in the informed consent form.

Name:_____Date:_____

Address:_____City:_____Zip:_____

Social Security #:_____ Date of Birth:_____

Telephone: H: _____W: _____Cell: _____

May I leave a message? If so, on which number? _____

E-mail:_____ May I e-mail you?_____
May I text you?_____
*Please note: Email and Text correspondence is not considered to be a confidential medium of communication.

Occupation:_____Employer/School:_____

Emergency Contact:_____Phone:_____
Relationship:_____

Medical Doctor/s
(Name/Phone):_____

Referral Source:_____

Education: _____Current Marital Status:_____

Children (Names/Ages)_____

Insurance Carrier: _____

Phone Number on Card:_____

Policy ID Number:_____Group Number:_____

Primary Policy Holder's Name:_____Date of Birth:_____

Reason for Visit:_____

_____

The following is a list of common obstacles that often lead people to seek professional assistance. Please check those you feel may apply to you, or add any that you would like to address:

___Anxiety ___Addictions ___Self Esteem
___Depression ___Alcohol ___Eating Disorders
___Stress/Tension ___Drugs ___Weight Control
___Communication ___Relationships ___Personal Image
___Work Problems ___Sexuality ___Grief/Loss
___Abortion ___Guilt Feelings ___Emotional Pain
___Physical Pain ___Panic Attacks ___Shyness
___Lack Motivation ___Suicidal Thoughts ___Suicide Attempts
___Physical Abuse ___Sexual Abuse ___Phobias
___Other:_____

Do you have any suicidal feelings? _____ For how long:_____

Have you ever attempted suicide? _____ How? _____

Have you previously received any type of mental health services?_____

Have you ever been prescribed psychiatric medication?_____
Name of drug:_____

Are currently taking any prescription medication?_____

Is there a family history of any of the following?
(Please Circle) (Family Member)

Alcohol Abuse: yes no _____

Substance Abuse: yes no _____

Depression: yes no _____

Suicide Attempts: yes no _____

Bipolar Disorder: yes no _____

Schizophrenia: yes no _____

Eating Disorders: yes no _____

Are you currently experiencing overwhelming sadness, grief or depression?
□ No □ Yes
If yes, for approximately how long?_____

Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No □ Yes

If yes, when did you begin experiencing
this?_____

Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please
describe?_____

How often do you drink alcohol? □Daily □Weekly □Monthly □Infrequently □Never
If you drink, how much on average do you
consume?_____

How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never. If yes, which
drug(s):_____

What are your religious or spiritual
beliefs?_____
_____

Are you currently in a romantic relationship?_____
For how long?_____

On a scale of 1-10, how would you rate this
relationship?_____

What significant life changes or stressful events have you experienced recently?
_____
_____

Have you ever received counseling?_____What did you
like/dislike_____
_____
_____

What are your strengths and areas for
improvement?_____
_____
_____

What do you expect to achieve through
therapy?_____
_____

FINANCIAL POLICY

Thank you for choosing Cynthia Kozmary as your Behavior Healthcare Provider. Please understand that payment for my services is part of your treatment. You are required to read and sign prior to treatment.

- **All Clients must complete the following forms before seeing the Provider:**
  - ☐ **Consent to Treat**
  - ☐ **Client Questionnaire**
  - ☐ **Financial Policy**
  - ☐ **HIPPA**
- **Current Insurance cards and a photo ID must be presented at your initial session for copying purposes.**

- **Full payment is due on the day and time of session for Cash Clients, unless PRIOR arrangements have been made.**

- **Co-pays, Co-insurance and Deductable payments are due on the day and time of your session.**

- **For your convenience, we accept cash, check, VISA and Mastercard (which includes Debit Cards)** A $2.00 fee will be added if you pay by credit card.

- **Any balance due from prior sessions must be paid prior to any subsequent sessions.**

- **Any Client who fails to show up for their session, and does not call at least 24 hours in advance, may be charged a fee of $100. (Your insurance company will not reimburse us for this fee, it is your responsibility)**

- **Please note: waiving insurance deductibles, co-pays and co-insurance is illegal and is a breach of contract with insurance companies, therefore, we are unable to waive any co-pays, etc.**

Thank you for your understanding and cooperation. Please let us know if you have any questions or concerns regarding this form.

I have read and understand the above Financial Agreement with Cynthia Kozmary (dba-Vegas Counseling Center, LLC.)

_____ _____
(Please print your name) (Date)

_____ _____
(Please sign your name) Provider Signature Date

HIPPA

Confidentiality Statement and the Health Insurance Portability & Accountability Act (HIPPA)

NOTICE OF PRIVACY PRACTICES

Effective Date: January 1, 2008

THIS NOTICE DESCRIBES HOW YOUR MEDICAL OR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As mental health professionals we are committed to protecting your health information. We are required by law to: maintain the privacy of your protected health information or PHI; give you a notice of our legal duties and privacy practices with respect to your PHI; and follow the terms of the Notice currently in effect.

This Notice of Privacy Practices is required by the Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we use and disclose information about you, called protected health information, to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition; or the provision or payment of your health care. This Notice of Privacy Practices applies to all of your PHI used to make decisions about your care that we generate or maintain. Different privacy practices may apply to your PHI that is created or kept by other people or entities. This Notice of Privacy Practices will be followed by all employees, students and volunteers associated with this mental health practice.

The following categories describe the ways that we may use and disclose your PHI with your consent. Not every use or disclosure in a category will be listed. If you do not consent, we cannot provide you with treatment except in an emergency situation or when we cannot communicate with you for some other reason. If you are concerned about a possible use or disclosure of any part of your PHI, you may request a restriction.

Treatment: We may use your PHI to provide you with medical treatment and services. We may disclose your PHI to physicians, nurses, technicians, medical students and other health care personnel who need to know your PHI for your care and continued treatment. We may share your PHI in order to coordinate services, such as prescriptions, lab work, x-rays and other services. For example, your physician may refer you to a specialist for additional treatment. The specialist may request additional information from your physician regarding your medical history. In addition, a physician may need to know the medications you were prescribed by the specialist so that he can arrange for appropriate treatment and follow-up care. We may use and disclose your PHI to tell you about or arrange for possible treatment options for your continued care, such as rehabilitation, home care, family members or others.

Payment: We may use and disclose your PHI for the purpose of determining coverage, billing, collections, claims management, medical data processing and reimbursement. PHI may be released to an insurance company, third party payer or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record that are necessary for payment of your account. For example, a bill sent to a third party payer may include information identifying you, your diagnosis, and procedures

and supplies used. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or determine whether your plan will cover the treatment.

Business Associates: We may disclose your PHI to business associate with whom we contract to provide services on our behalf that requires the release of PHI. However, we only will make these disclosures if we have received satisfactory assurance that the other entity will properly safeguard your PHI. For example, we may contract with another entity to provide transcription or billing services.

SPECIAL CIRCUMSTANCES
Emergencies: Your authorization is not required if you need emergency treatment. We will try to get your authorization as soon as practical after the emergency.
Mental Health/Substance Abuse: In certain circumstances, we may not disclose your PHI, including psychotherapy notes, to you without the written consent of your physician or to others without your written authorization or a court order.

DISCLOSURES REQUIRING YOUR AUTHORIZATION
Family/Friends: Unless you object orally or in writing, we may disclose your PHI to a friend or family member who is involved in your medical care or who helps pay for your care. We may disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you are unable or unavailable to agree or object, we will use our best judgment in communicating with your family and others.
Appointment Reminders: We may use and disclose your PHI to contact you as a reminder that you have an appointment for treatment or medical care. This may be done through an automated system or by one of our staff members. If you are not home, we may leave a message on an answering machine or with the person answering the phone.
Other Uses: We must obtain a separate authorization from you to use or disclose your PHI for situations not described in this Notice.

CERTAIN USES/DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION:
Regulatory Agencies: We may disclose your PHI to a health oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations, inspections and medical device reporting. We may provide your PHI to assist the government when it conducts an investigation or inspection of a healthcare provider or organization.
Law Enforcement: We may disclose your PHI if asked to do so by a law enforcement official: (i) in response to a court order, warrant, summons or other similar process; (ii) to identify or locate a suspect, fugitive, material witness, or missing person; (iii) about the victim of a crime, if under limited circumstances, we are unable to obtain the persons agreement; (iv) about a death we believe may be the result of criminal conduct; (v) about criminal conduct at the Health and Wellness Center; and (vi) in emergency circumstances to report a crime; the location of a crime or victims, or the identity, description or location of the person who committed the crime.
Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may disclose medical information about you in response to a subpoena or discovery request, but only if efforts have been made to inform you about the request or to obtain an order protecting the information requested, unless the physician-patient privilege has been waived.
Judicial and Administrative Proceedings: We may disclose your PHI in the course of any administrative or judicial proceeding.
To Avoid Harm: In order to avoid a serious threat to the health and safety of a person or the public, we may disclose PHI to law enforcement personnel or persons able to prevent or lessen such harm. We may notify a person who may have been exposed to a disease or may be a risk

for contracting or spreading a disease or condition as ordered by public health authorities or allowed by state law.
Required by Law: We will disclose your PHI when required to do so by federal or state law. For example, we are required to report suicidal or homicidal threats when it is determined that the threat will likely be carried out. We are also required to report child and elder abuse as mandated by the Nevada Revised Statues.

PATIENT HEALTH INFORMATION RIGHTS
Although all records concerning your treatment at our mental health offices are the property of the individual clinician that you are seeing, you have the following rights concerning your PHI.
Right to Confidential Communications: You have the right to receive confidential communications of your PHI by alternative means or at alternative locations. For example, you may request that we only contact you at work or by mail. You must submit your request in writing and identify how or where you wish to be contacted. We will accommodate all reasonable requests.
Right to Inspect and Copy: You have the right to inspect and copy your PHI as provided by law. This right does not apply to psychotherapy notes. A request must be made in writing. We have the right to charge you the amounts allowed by state or federal law for such copies. We may also charge for postage if you request that we mail the information. We may deny your request to inspect and copy in certain circumstances. If you are denied access, you may request that the denial be reviewed. A licensed healthcare professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
Right to Amend: If you feel that the PHI we have about you is incorrect or incomplete, you have the right to request an amendment of your PHI. We cannot delete or destroy any information already included in your record. You must submit your request in writing and provide a reason that supports your amendment request. We may deny your request for an amendment if it is not in writing, does not include a reason to support the request; or the information (i) was not created by us (unless the person or entity that created the information is not available to make the amendment; (ii) is not part of the medical record that we maintain; (iii) is not part of the information that you would be permitted to inspect or copy; or (iv) is accurate and complete.
Right to an Accounting: You have the right to obtain a statement of certain disclosures of your PHI to third parties, except those disclosures made for treatment, payment or healthcare operations or authorized pursuant to this Notice. To request this list, you must submit your request in writing and state a time period no longer than six (6) months which may not include dates prior to April 14, 2003. If you request more than one (1) accounting in a 12-month period, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to modify or withdraw your request before any costs are incurred.
Right to Request Restrictions: You have the right to request restrictions or limitations on PHI we use or disclose about you unless our use or disclosure is required by law. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you may want to pay cash for certain services instead of having information submitted to your insurance company for payment. We are not required to honor your request. To request restrictions, you must make your request in writing and tell us (i) what information you want to limit; (ii) whether you want to limit our use, disclosure or both; and (iii) to whom you want the limits to apply. If we agree, we will comply with your request unless the information is needed to provide emergency treatment to you.

Right to Receive Copy of this Notice: You have the right to a paper copy of this notice.
Right to Revoke Authorization: You have the right to revoke your authorization to use or disclose your PHI, EXCEPT to the extent that action has already been taken by us in reliance on your authorization.

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions and would like additional information, you may speak with your individual mental health provider. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. To file a complaint with DHHS, you must submit a written complaint within 180 days of when you knew or should have known that the act or omission complained of occurred. Our Privacy Official can provide you with current contact information. You will not be penalized for filing a complaint.

CHANGES TO THIS NOTICE: We will abide by the terms of the notice currently in effect. We reserve the right to change the terms of its notice and to make the new notice provisions effective for all PHI we maintain.

NOTICE EFFECTIVE DATE: January 1, 2012

Signature:_____Date:_____