

**Karen M. Tolen, MPH, MSW, LMSW/LCSW
Individual, Family, Marriage Therapy**

**Notice of Privacy Practices
HIPAA [Health Information Portability & Accountability Act]**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND SIGN THAT YOU HAVE RECEIVED A COPY.

My office is committed to and practices the following guidelines in order to protect the privacy of your Protected Health Information (PHI). I am required by law, as well as by professional standards, to keep your health information private; to give you this notice of my privacy practices; and to let you know if I make any changes in them.

I consider all information about our work to be confidential. Your signature on the Receipt and Acknowledgement Form presents acknowledgement stating that you have received and reviewed this notice and gives me your consent to use and/or disclose your PHI for payment purposes. Unless you request otherwise, I may disclose your PHI orally, on paper or electronically. I may not disclose your PHI without your informed and voluntary written consent or authorization (see also my Office Practices and Policies information).

Disclosure of Information

Whenever your PHI is released or obtained, it will be the minimum information necessary. There are some situations in which release of information without authorization is required and/or permitted by law and professional ethics. These include:

- Emergencies
- Reporting of abuse or neglect
- Disclosures required by court order
- Disclosures necessary to prevent or lessen serious and imminent threat to the health and safety of a person or the public.

Karen M. Tolen, MPH, MSW, LMSW/LCSW

Your Rights Regarding Privacy

By law, you have certain rights regarding the health information that I collect and maintain about you. These rights include:

- The right to inspect and obtain a copy of your medical record.
- The right to request an amendment of any section of your medical record.
- The right to request restrictions of disclosure of your PHI for the purposes of treatment and/or payment.
- The right to request an accounting of the disclosures that I make use of your health care information.
- The right to request confidential communication.
- The right to a copy of this notice.
- The right to refuse to acknowledge receipt of this notice.

Questions and/or Exercising Your Rights

If you have any further questions and/or concerns about this notice or to exercise any of your above rights, please contact Karen M. Tolen, MPH, MSW, LMSW/LCSW at 919-801-1624.

If you believe your privacy rights have been violated, you may file a written complaint with Karen M. Tolen. You may also contact the appropriate state licensing board. You will not be penalized for doing so.

I reserve the right to amend the terms of this notice.

THIS NOTICE IS EFFECTIVE APRIL 1, 2011.

This notice was reviewed July 20, 2018.

This notice was reviewed September 18, 2018.

This notice was revised February 1, 2022.

This notice was revised June 17, 2022.

Karen M. Tolen, MPH, MSW, LMSW/LCSW

Individual, Family, and Marriage Therapy

OFFICE POLICIES AND PRACTICES

Appointments and Communications: Appointments are scheduled directly with me. I may be reached by phone, text, email and FaceBook Messenger. If you call and I'm not available, please leave a message and I will return your call at my earliest convenience. I check phone messages frequently throughout the day.

If your schedule permits, negotiating a weekly standing appointment saves time and insures your access to more flexible hours. If you cannot arrange a standing appointment, it may be best to schedule your appointments well in advance in order to maximize your choice of available appointment hours.

If you have access to a printer, prior to arrival download the PDF forms from the website (found under "Services") and submit the completed copies prior to the first session.

Cancellations: Notice of cancellations must be made a full 24 hours before your scheduled appointment. A fee of \$50 will be charged for late cancellations and missed appointments. Exceptions to this policy include dangerous weather conditions, serious illness or accident, or family emergency.

Financial Agreement: Payment for service is due prior to or at the beginning of each session. Please complete any check preparation outside the session. I accept cash and checks; no credit cards. I do not keep change/cash, so please have the exact payment amount. A receipt will be given for each payment.

Insurance: I do not accept insurance payments, nor am I on any insurance panels.

Taxes: Therapy fees constitute a tax deductible medical expense if you qualify. Please check with your tax preparer for eligibility to use psychotherapy payments toward your medical expenses.

Confidentially: I preserve the confidentiality of all clients and ask that you do the same by not disclosing the identity of any clients seen at the office location or information acquired via contact with other clients. If you see me in public, I will leave it to you to acknowledge me first, and there will never be any discussion of any personal business. Any violation of confidentiality may be reported to the appropriate state Board of Social Workers.

CONTRACT

I have read the Office Policies and Practices and accept responsibility for the financial agreement, cancellation policy, and issues of confidentiality.

Fee Per Hour

Client Signature/Date

(919) 801-1624

kmoore325@frontier.com

Karen M. Tolen, MPH, MSW, LMSW/LCSW

Consent For Treatment

I, _____,

give permission to Karen Tolen for psychotherapy treatment.

Signed

Date

Karen M. Tolen, MPH, MSW, LMSW/LCSW

CONSENT FOR RELEASE OF INFORMATION

I, _____, agree that Karen Tolen has my permission to release any information about me and my treatment for the purpose of treatment and/or coordination of services to the following:

1. _____
2. _____
3. _____
4. _____

This permission is good for one year, ending on _____.

Client Signature

Date

(919) 801-1624

kmoore325@frontier.com

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Receipt and Acknowledgement Form

I acknowledge that a copy of Karen M. Tolen's Health Information Portability & Accountability Act (HIPPA) policy has been provided to me, that I understand the policy, and that I agree with Karen M. Tolen's policy regarding HIPPA.

Client Signature

Date

(919) 801-1624

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CONTACT FORM

Name

Home Telephone

Cell

Work Telephone

Is it permissible to leave a message for you at these numbers? _____

Street Address

Mailing Address, if different

Contact Name and Relationship in event of emergency

Emergency Contact's Address and Telephone

How did you find out about my service?

TODAY'S DATE

Email Address

(919) 801-1624

kmoore325@frontier.com