Liberty House
375 Taylor Street NE
Salem, OR 97301

Client Rights & Responsibilities

Thank you for choosing Liberty House Center to receive mental health services. We understand that beginning counseling is a huge step and you may have many questions. The following pages will hopefully help answer those questions and also inform of your rights.

Services are voluntary and clients have a right to discontinue treatment at any time. It is our mission to provide assessment, counseling and support to children and families facing concerns of abuse and neglect in a safe, comfortable, and child-friendly environment. The following is a summary of your rights and responsibilities. If you have any other questions or concerns, please feel free to ask your therapist.

Basic Rights:

- You have a right to access and receive services regardless of race, color, religion, sex, sexual orientation, national origin, and mental or physical limitation.
- You will be treated with respect and dignity.
- You will receive courteous and timely service in an environment that offers reasonable safety and privacy.
- You will receive services from a counselor who has met at least the minimal qualifications of training and experience required by state law.
- You have the right to be free from seclusion, restraint, abuse or neglect.
- You may report any incident of abuse or neglect, as well as other concerns, without retaliation.

Access and Information Rights:

- You can receive services in a manner and language consistent with your culture, including access to an interpreter if needed.
- You will be asked to give written informed consent prior to the start of services.
- You will be informed of the cost of services and any financial obligations you may have.
- You may receive services without parent or guardian consent when lawfully married, emancipated, or age 14 or older for outpatient services.
- You have the right to receive care for mental health emergencies 24 hours per day, 7 days a week either via telephone or in person. You and your therapist may define together what constitutes a mental health emergency.

Your Treatment Rights:

- You will receive quality, trauma-sensitive care.
- You will receive information from your therapist about their credentials (including a Professional Disclosure Statement, depending upon licensure)
- You will be an active participant in developing your goals for treatment and ensuring that the services received are consistent with your goals.

- You may receive a written copy of the service plan identifying goals and services.
- You have the right to ask about risks and benefits of treatment and other treatment options available.
- You may, upon written request, receive a copy of any mental health documents originating from Liberty House. There will be a fee to account for the copy costs.
- You must give written permission before information about you or your treatment can be shared with anyone outside of Liberty House. Your information and services provided to you will be kept confidential per state and federal laws, unless it falls under the following exceptions:
    - Reporting suspected child abuse, elder abuse, neglect or domestic violence in the presence of children, whether past or present
    - Reporting imminent danger to client or others
    - Reporting information required by your insurance company for reimbursement
    - Reporting to other relevant agencies as required by mandate. For instance, an agreement has been created between the OHP system and local doctors that allows for exchange of protected health information to provide for more comprehensive client care.
    - Responding to a court order
    - Defending claims brought against a therapist to their governing licensing board
- You have a right to refuse treatment at any time.
- You have the right to file a written or oral complaint relating to treatment or providers and receive assistance in filing the complaint.
- You have the right to create a Declaration of Mental Health Treatment and receive help completing the declaration (adults only).
- You have the right to receive information about medical Advanced Directives.
- You will receive prior notice of service conclusion or transfer, if services will be reduced or terminated.

Your Responsibilities:

- You will treat others with courtesy and respect.
- You will provide information needed in order to provide care.
- You will participate, as much as possible, in developing mutually-agreed upon service goals.
- You will follow the service plans you have agreed to.
- You will inform providers of any dissatisfaction with services.
- **You will arrive on time for scheduled appointments. If you are more than 10 minutes late, your appointment will be cancelled.**
- **You will call 24 hours or more ahead if you are unable to attend your scheduled appointment. Two or more late cancellations or no-shows will likely result in your provider asking you to complete an attendance contract with them.**
- You will inform providers of any changes in address, telephone numbers, and other personal information relating to treatment.
- You will bring insurance information and cards to appointments and inform providers of any changes in coverage.

- You will seek help for any addiction or mental health issue that may interfere with treatment.
- You will protect the confidentiality and safety of other individuals.
- You will not make threats of harm to other individuals, staff or providers, nor destroy property. The consequences of such behavior may result in immediate termination of services to protect the safety of others.
- You will use a respectful volume when speaking, being mindful that yelling may limit your privacy and trigger other individuals receiving services.
- You will pay for any services detailed in the fee agreement.
- You will use the on-call, after-hours service only for mental health emergencies, as defined between you and your provider.
- You understand that any email communication is not secure. Thus, you are asked to refrain from emailing treatment related issues. Any email sent will become part of your client record.

I am acknowledging that I have read through my rights and responsibilities as a client at Liberty House. Furthermore, I agree that I will abide by the responsibilities identified above and that any support persons that accompany me to my appointments will also be expected to adhere to these responsibilities.

Client: _____ DOB: _____
Signature (if 14 or older)

Client: _____ Date: _____
Printed Name

Parent/Guardian: _____ Date: _____
Signature

Parent/Guardian: _____
Printed Name

Therapist: _____ Date: _____
Signature

Therapist: _____
Printed Name

Liberty House
375 Taylor Street NE
Salem, OR 97301

Notice of Privacy Practices Acknowledgement

By signing this document, I am acknowledging that I have received a copy of the Liberty House **Notice of Privacy Practices**, which describes how Liberty House may use and/or disclose my or my child's health information. I understand that Liberty House has the right to change its **Notice of Privacy Practices** from time to time and that I may contact Liberty House at any time to obtain a current copy of the **Notice of Privacy Practices**. I understand that I may refuse to sign this form.

Name of Patient: _____ DOB: _____

Signature: _____ Date: _____
(Patient if age 14 or older)

Name of Patient's Representative:

Please Print Name: _____

Signature: _____ Date: _____

Relationship to patient: _____

For Office Use

Notice of Privacy Practices Given: ☐ yes ☐ no
Notice of Privacy Practices Accepted: ☐ yes ☐ no

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient, but it could not be obtained because:

☐ The patient/patient representative refused to sign
☐ Due to an emergency situation, it was not possible to obtain an acknowledgement
☐ We were not able to communicate with the patient/patient representative
☐ Other (please provide details)

_____

_____ _____
Employee Signature Date

Liberty House
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Client Email/Texting Informed Consent Form

We understand that email and texting are often preferred means of sharing information outside of sessions. However, it is important to understand there may be risks associated with email and/or texting. These risks include, but are not limited to:

- Email and texts can be forwarded, stored electronically and on paper, and shared with unintended recipients. While the staff at Hope & Wellness Services will not intentionally share emails or texts with uninvolved parties, emails and texts may not be secure and may be breached by a third party.
- Back-up copies of emails and texts may exist on servers or the Cloud even after the sender and/or recipient has deleted their copies.
- Employers and online services have a right to inspect emails sent through their company systems.
- Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
- Emails and texts can be subpoenaed and used as evidence in court.

Your therapist cannot guarantee, but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Liberty House and the Hope & Wellness services staff are not liable for improper disclosure of confidential information that is not caused by staff's intentional misconduct. Clients and/or guardians must acknowledge and consent to the following conditions prior to any email or texting exchange of information:

- Email and texting are not appropriate for urgent or emergency situations. Your therapist cannot guarantee that emails and/or texts will be read and responded to within a set amount of time.
- Emails and texts should be fairly brief. The client and/or guardian should call or schedule an appointment to discuss complex or sensitive situations.
- Therapists appreciate brief emails prior to appointments that provide updates when caregivers of child clients are not able to check in personally. However, therapists will not respond in-depth to any concerns identified in email. Instead, the caregiver will be asked to schedule a session or phone call with the therapist.
- Emails and texts should not include a client's full name or other identifying information beyond first name or initials.
- Hope & Wellness Services staff will send all emails with confidential information via an encryption service.
- All email will be printed and filed into the client's electronic health record. Text messages will be screen shot and/or recorded verbatim and placed in the client record as well.

- Your therapist will not forward a client's or guardian's email without written consent, except as authorized by law.
- Liberty House and the Hope & Wellness Services staff are not liable for breaches of confidentiality caused by the client or any third party.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions outlined above.

Client: _____ Date: _____
Signature (if 14 or older)

Client: _____ DOB: _____
Printed Name

For clients under 14:

Parent/Guardian: _____ Date: _____
Signature

Parent/Guardian: _____
Printed Name

Provider: _____ Date: _____
Signature

Provider: _____
Printed Name

Liberty House
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Salem, OR 97301

Policy Statement Regarding Requests to Write Letters in Support of Emotional Support Animals

Thank you for choosing Liberty House Center to receive counseling services for you or your child. On occasion, therapists have been asked to write letters or complete housing forms in support of an emotional support animal for a client or household. Prior to explaining the policy adopted by the Hope & Wellness Program, it is necessary to define an Emotional Support Animal versus a Service Animal.

Definitions:

Service Animal (Assistance Animal): A dog or animal designated by administrative rule that has been individually trained to do work or perform tasks for the benefit of an individual.

Companion Animal: An animal that provides emotional support, comfort or companionship.

It is the policy of Liberty House Hope & Wellness Program to **not** write such letters for the following reasons:

1. A review of literature in a study published in the *Professional Psychology: Research and Practice Journal, 2016* found little evidence showing emotional support animals are more effective than traditional pets in helping their owners.

2. There are currently no standards for evaluating emotional support animals. Writing such a letter would require observing the animal with the person requesting the letter and determining the positive impact of the animal, as well as any possible negative effects without the animal.

3. The APA Ethics Code forbids therapists from providing information about a client's mental health condition to a third party for nonclinical purposes. A letter supporting the need for an emotional support animal is a formal certification of psychological disability and would need to be provided from someone completing a forensic evaluation, such as a licensed psychologist or medical doctor.

Client/Guardian Agreement: I have read this information and have had an opportunity to ask questions. My signature below indicates that I have read and understand this policy statement.

Client: _____ Date: _____
Signature (if 14 or older)

Client: _____ DOB: _____
Printed Name

For clients under 14:

Parent/Guardian: _____ Date: _____
Signature

Parent/Guardian: _____ Date: _____
Printed Name

Therapist: _____ Date: _____
Signature

Therapist: _____
Printed Name

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Liberty House Mental Health Program
Fee Agreement

Liberty House has established a fee scale for services provided by all Master's Level Counselors. I understand I am required to pay based on my level of insurance coverage.

I agree I will be held responsible for all co-payments and pay at the time of service.

Furthermore, if I receive a service not covered by my insurance (e.g., case management is not covered by most private insurances), I will be held responsible to pay for the service.

Finally, I agree to report any changes in my insurance coverage as soon as I become aware of them. If my coverage is terminated or does not cover mental health services, I understand I will be held responsible for any fees incurred following the change in coverage.

Please speak with the Client Services Specialist if you have further questions regarding the fees.

SERVICE	FEE
Mental Health Assessment	$ 192.45
Individual Therapy; 16-37 minutes	$ 86.85
Individual Therapy; 38-52 minutes	$ 120.90
Individual Therapy; 53 + minutes	$ 177.95
Family Therapy	$ 177.70
Crisis Therapy (in person only)	$ 191.00
Group Therapy	$ 59.25
Case Management; per every 15 minutes	$ 29.60
Consultation	$ 118.45
Annual Service Plan Development	$ 144.35
Add On Service (services that occur in addition to one of those identified above):	
Interactive Complexity (disclosure of a reportable event; addressing emotions or behaviors that interfere with service delivery; using play or other devices or translator to overcome barriers in communication)	$ 11.80
Crisis therapy beyond an hour	$ 86.85
Late Cancellation (less than 24-hour notice)**/No Show Fee**	**$ 35.00**

Client/Parent/Legal Guardian: _____ Date: _____
Signature

Client/Parent/Legal Guardian: _____
Printed Name

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Consent for Treatment

I have read and/or had the following explained to me as part of my/my child's intake into mental health services at Liberty House (initial those that apply):

_____ Client Rights and Responsibilities

_____ Complaint Process

_____ Fee Agreement

_____ Notice of Privacy Practices

_____ Benefits and Risks of Treatment

_____ I agree that the Liberty House Child Abuse Assessment Clinic and Hope & Wellness Program may exchange my/my child's personal health information for the purpose of, and when necessary for: evaluation; treatment; care coordination; and/or continuing care. (Initial line for consent).
Approximate Date(s) of Liberty House Assessment: _____

The Hope & Wellness Program also has access to Collect Medical Platform, a care coordination tool that provides real-time information on clients accessing the local Emergency Departments.

As part of the Hope and Wellness Program's agreement, Collect Medical Platform will be utilized to ensure therapists are connecting with clients following hospital admissions when clinically appropriate. This **may** include a follow-up phone call from your therapist for physical health concerns, in addition to any concerns related to mental health.

I give Liberty House permission to provide me/my child with mental health assessment and treatment services.

Client: _____ Date: _____
Signature (if 14 or older)

Client: _____ DOB: _____
Printed Name

Parent/Guardian: _____ Date: _____
Signature

Parent/Guardian: _____
Printed Name

For Staff Use Only

Requesting Therapist: _____ Date: _____

Request Received By: _____ Date: _____

Liberty House
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Salem, OR 97301

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I authorize Liberty House to disclose and exchange mental health information described below regarding:

_____ _____
(Name of Client) (Date of Birth)

To/From: Primary Care Physician: _____
(Please list name and address of recipient)

Consisting of:

Mental Health Information, including but not limited to attendance, treatment goals, session content, and diagnoses _____ Initial: _____

Other: _____ Initial: _____
(Please describe information to be used/disclosed)

For the purposes of: _____
(Please describe each purpose of disclosure or state "at the request of the individual" if this authorization is initiated by the individual and the individual does not, or elects not to, provide a statement of purpose):

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of (1) creating health information about you to be disclosed to a third party; or (2) for the purpose of research.

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to the Custodian of Records at Liberty House, 2685 4th Street NE, Salem OR 97301, that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization.

This authorization will expire on the earlier of either _____ (date) or one year from the date of signing.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Client Signature: _____ Date _____
(if 14 or older)

Parent/Guardian Signature: _____ Date _____

Parent/Guardian Printed Name: _____

Liberty House
375 Taylor Street NE
Salem, OR 97301

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I authorize Liberty House to disclose and exchange mental health information described below regarding:

_____ _____
(Name of Client) (Date of Birth)

To/From: _____
(Please list name and address of recipient)

Consisting of:

Mental Health Information, including but not limited to attendance, treatment goals, session content, and diagnoses _____ Initial: _____

Other: _____ Initial: _____
(Please describe information to be used/disclosed)

For the purposes of: _____
(Please describe each purpose of disclosure or state "at the request of the individual" if this authorization is initiated by the individual and the individual does not, or elects not to, provide a statement of purpose):

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of (1) creating health information about you to be disclosed to a third party; or (2) for the purpose of research.

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to the Custodian of Records at Liberty House, 2685 4th Street NE, Salem OR 97301, that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization.

This authorization will expire on the earlier of either _____ (date) or one year from the date of signing.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Client Signature: _____ Date _____
(if 14 or older)

Parent/Guardian Signature: _____ Date _____

Parent/Guardian Printed Name: _____

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Client Questionnaire

Client's Name: _____ DOB: _____

With which ethnicity do you identify?

- ☐ Asian American
- ☐ African American
- ☐ Middle Eastern
- ☐ White/Caucasian
- ☐ Native American/Alaskan Native
- ☐ Multiracial
- ☐ Hispanic/Latino(a)
- ☐ Pacific Islander
- ☐ Choose Not to Respond

Your answers to the following questions can be beneficial for your therapist as you identify concerns and goals for treatment. Please answer the questions below as completely as possible. Thank you.

About Family:

Household Members (list all persons living in the home starting with client named above):

Name (First, Last)	Gender	Age	Birthdate	Relationship to Client Named Above

Identify other important family members not living in the home (include birth parents or step-parents for child client, or extended relatives and friends that are good supports):

Name (First, Last)	Gender	Age	Birthdate	Relationship to Client Named Above

About Counseling:

Briefly describe the concern(s) that bring you to counseling: _____

_____

_____

What have you done to try to resolve this concern? _____

_____

How will you know that you or your child no longer need services (e.g., what will be better by end of counseling)? _____

_____

_____

Please check any of the following that the identified client is currently experiencing:

☐ Distractibility	☐ Sadness/depression	☐ Irritability/anger
☐ Hyperactivity	☐ Lack of motivation	☐ Aggression/fights
☐ Impulsivity	☐ Withdrawal from people	☐ Difficulty making friends
☐ Difficulty completing tasks	☐ Hopelessness	☐ Difficulty parenting
☐ Difficulty organizing	☐ Loneliness	☐ Obsessive thoughts
☐ Often loses important items	☐ Suicidal thoughts/attempts	☐ Compulsive behaviors
☐ Poor memory/confusion	☐ Self-harm	☐ School problems
☐ Anxiety/worry	☐ Change in appetite	☐ Substance abuse
☐ Fear about being away from home or caregiver	☐ Loss of interest in things that used to be enjoyed	☐ Visual or auditory hallucinations
☐ Panic attacks	☐ Eating problems	☐ Homicidal thoughts
☐ Sleep problems	☐ Social anxiety	☐ Flashbacks
☐ Nightmares/terrors	☐ Low self-worth	☐ Racing thoughts
☐ Suspicious/paranoid	☐ Guilt/shame	☐ Foster care/DHS
☐ History of firesetting	☐ Mean to animals	☐ Poor boundaries
☐ Sexual activity	☐ Exposure to pornography	☐ Difficulties with attachment

Please list previous mental health or substance abuse treatment for anyone in the home (include providers, dates, and any previous hospitalizations): _____

_____

_____

Has anyone in the home experienced suicidal thoughts? ☐ No ☐ Yes If yes, please describe: _____

_____

_____

Has anyone in the home experienced abuse, domestic violence, neglect or significant loss?

☐ No ☐ Yes If yes, please describe: _____

_____

_____

_____

Has there been any legal or child welfare involvement? ☐ No ☐ Yes If yes, please describe: ___

_____

_____

DHS Caseworker, please provide a copy of all 307s with this document and history of placements, including reasons for placements.

About Medical History:

Current Primary Care Physician: _____ Phone #: _____

PCP Clinic Name and Address: _____

Date of client's last physical exam? _____ Reason: _____

Known Allergies: _____

Current Medications and Prescriber: _____

_____

For child client, were there any complications during labor and delivery? ☐ No ☐ Yes If yes, please describe: _____

Were developmental milestones within the normal range for your child (e.g., walking, talking, pottying, etc.)? ☐ No ☐ Yes If no, please describe: _____

_____

About School (for child client):

Current School: _____ Grade: _____

Is your child on an IEP or 504 Plan? ☐ No ☐ Yes If yes, please describe: _____

_____

Please describe any concerns related to school (e.g., learning deficits, behavioral issues, etc.): _____

_____

_____

Other Important Details:

Briefly describe your social support (e.g., friends, youth groups, activities or sports involvement, family support, etc): _____

Do you feel like you and/or your family has an adequate support system? ☐ No ☐ Yes

Is there anything else you feel is important for me to know about you or your child (if identified client)?

_____

_____

Emergency Contact Information:

Name: _____ Phone: _____

Relationship to Client: _____

Thank you for answering these questions!

Liberty House
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Salem, OR 97301

Complaints Process

You have a right to receive services consistent with your goals and needs. If you are dissatisfied with your services or feel your rights have been violated, we ask that you follow the process described below:

1. Discuss the problem or situation with your counselor. If your concerns are not addressed to your satisfaction, you may discuss it with the Mental Health Program Manager.

OR

2. If you prefer to file a complaint, you or a person acting on your behalf, can submit a verbal or written complaint.

To File a Complaint:
You may request a form from the staff in the lobby area. You may also file a verbal complaint with the Mental Health Program Manager.

If you need help filling in the complaint form, you may ask the staff in the lobby area and they will either assist you or find someone who can.

Be sure to explain what happened and what you would like to see happen to resolve your complaint.

Following a Complaint:
Your complaint will be reviewed within 3 days of turning it in. Within 5 days, a letter will be sent in the mail that describes how the complaint has been or will be resolved.

If your complaint cannot be resolved within 5 days, the letter will explain why more time is needed to review your concern. If this happens, we will respond with a resolution within 30 days of the date you submitted your concern.

All complaints, related information, and resolutions will be sent to the Liberty House Quality Management Committee for review.

Further Action:
If you are satisfied with the resolution, then no further action will be taken. However, if you are not satisfied, you may discuss your situation further with the appropriate Manager.

You may also submit a complaint through the Oregon Addictions and Mental Health Division at https://www.oregon.gov/oha/amh/Pages/AMH-Complaint-Page.aspx or by contacting the Division of Medical Assistance Programs Client Services at 1 (800) 273-0557.

Liberty House
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Salem, OR 97301

Complaints Form

Client Name: _____ Date: _____

Provider: _____

Person Completing the Form (if different from client): _____

Describe the concern you have (what happened and when).

What would you like to see happen to resolve your complaint?

Signature: _____ Date: _____

Received in office by: _____ Date: _____

Liberty House
375 Taylor Street NE
Salem, OR 97301

NOTICE OF PRIVACY PRACTICES FOR MENTAL HEALTH TREATMENT

Effective Date: June 23, 2017

THIS NOTICE DESCRIBES HOW MEDICAL AND MENTAL HEALTH INFORMATION ABOUT YOU/YOUR CHILD 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, please contact the Liberty House Office Manager at

Liberty House
2685 4th Street NE
Salem, OR 97301
503-540-0288

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other personnel.

YOUR/YOUR CHILD'S HEALTH INFORMATION

This notice applies to the information and records we have about you/your child's, your/your child's health, health status, and the health care and services you receive from Liberty House. Your/your child's health information may include information created and received by Liberty House, may be in the form of written or electronic records or spoken words, and may include information about your/your child's health history, health status, mental health, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you/your child and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU/YOUR CHILD

We may use and disclose health information for the following purposes:

For Treatment. We may use health information about you/your child to provide you/your child with mental health treatment or services. We may disclose health information about you/your child to other personnel who are involved in taking care of you/your child and your/your child's health.

For example, therapists receive regular supervision and may consult about your child's treatment to develop other strategies that may address your concerns and goals.

Different personnel in our organization may share information about you/your child and disclose information to people who do not work for Liberty House in order to coordinate your/your child's care, such as requesting medication evaluation. Other health care providers may be part of your/your child's medical care outside this office and may require information about you/your child that we have.

For payment. We may use and disclose health information about you/your child so that the treatment and

services you/your child receive at Liberty House may be billed to and payment may be collected from you, an insurance company or a third party such as Crime Victims Compensation.

For example, we may need to give your/your child's health plan information about a service you/your child received here so your/your child's health plan will pay us for the service. We may also tell your/your child's health plan about a treatment you/your child are going to receive to obtain prior approval or to determine whether your/your child's plan will pay for the treatment.

For Health Care Operations. We may use and disclose health information about you/your child in order to manage Liberty House and make sure that you/your child and our other patients receive quality care.

For example, we may use your/your child's health information to evaluate the performance of our staff in caring for you/your child. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

We may also disclose your/your child's health information to health plans that provide you/your child insurance coverage and other health care providers that care for you/your child. Our disclosures of your/your child's health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

SPECIAL SITUATIONS

We may use or disclose health information about you/your child for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you/your child when necessary to prevent a serious threat to your/your child's health and safety or the health and safety of the public or another person.

Required By Law. We will disclose health information about you/your child when required to do so by federal, state or local law. For example, state law may require that we disclose PHI to certain federal, state, local and private agencies involved in child abuse investigations, including the review of such investigations.

Research. We may use and disclose health information about you/your child for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your/your child's name, address or other information that reveals who you are or who your child is, or will be involved in your/your child's care at the office.

Organ and Tissue Donation. If you or your child are/is an organ or tissue donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence. If you/your child are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you/your child. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release health information about you/your child for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose health information about you/your child for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities. We may disclose health information to a health oversight agency for audits,

investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you/your child in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you/your child in response to a subpoena.

Law Enforcement. We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable. We may use or disclose health information about you/your child in a way that does not personally identify you/your child or reveal who you are or who your child is.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your/your child's health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you/your child for any reason not listed above, you may revoke that *Authorization*, **in writing**, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you/your child for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as substance abuse information for purposes such as treatment, payment and healthcare operations.

YOUR/YOUR CHILD'S RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU/YOUR CHILD

You have the following rights regarding health information we maintain about you/your child:

Right to Inspect and Copy. With some exceptions, you have the right to inspect and copy your/your child's health information, such as medical and billing records, that we keep and use to make decisions about your/your child's care. You must submit a written request to the Liberty House Office Manager in order to inspect and/or copy records of your/your child's health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your/your child's medical record.

If you request to view a copy of your/your child's health information and the request is approved, we will not charge you for inspecting your/your child's health information. If you wish to inspect your/your child's health information, please submit your request in writing to the Liberty House Office Manager. You have the right to request a copy of your/your child's health information in electronic form if we store your/your child's health information electronically.

We may deny your request to inspect and/or copy your/your child's record or parts of your/your child's record in certain circumstances. Under the law, you may not have a right to access information compiled in reasonable anticipation of or for use in a civil, criminal or administrative proceeding. You also may not have the right to access information that was obtained from someone else under a promise of confidentiality.

If you are denied copies of or access to, health information that we keep about you/your child, you may ask

that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review. **Please note that a decision will not be made at the time that your request is submitted. You will be contacted about the decision within 60 days.**

Right to Amend. If you believe health information we have about you/your child is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by Liberty House.

To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to the Liberty House Office Manager.

We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information that we keep
- You would not be permitted to inspect and copy
- We believe is accurate and complete

If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your/your child's medical record. Your rebuttal needs to be five (5) pages in length or less and we have the right to file a rebuttal responding to yours in your/your child's medical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you/your child for purposes other than treatment, payment, health care operations, when specifically authorized by you/your child and a limited number of special circumstances involving national security, correctional institutions and law enforcement.

To obtain this list, you must submit your request **in writing** to the Liberty House Office Manager. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you/your child for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you/your child to someone who is involved in your/your child's care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you/your child had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you/your child emergency treatment or we are required by law to use or disclose the information.

We are required to agree to your request if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your/your child's health plan for payment

or health care operations purposes. There may be instances where we are required to release this information if required by law.

To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION to the Liberty House Office Manager.

Right to Request Confidential Communications. You have the right to request that we communicate with you/your child about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you/your child at work or by mail.

To request confidential communications, you may complete and submit the REQUEST FOR CONFIDENTIAL COMMUNICATION to the Liberty House Office Manager. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact the Liberty House Office Manager. You may also find a copy of this Notice on our web site.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you/your child as well as any information we receive in the future. We will post the current notice at our location(s) with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

We will inform you of any significant changes to this Notice. This may be through our newsletter, a sign prominently posted at our location(s), a notice posted on our web site or other means of communication.

BREACH OF HEALTH INFORMATION

We will inform you/your child if there is a breach of your/your child's unsecured health information.

COMPLAINTS

If you believe your/your child's privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at:

Office for Civil Rights Region X
U.S. Department of Health & Human Services
2201 Sixth Avenue – M/S: RX-11
Seattle, WA 98121-1831
Phone: 800-368-1019
Fax: 206-615-2297
TDD: 800-537-7697

To file a complaint with Liberty House, contact the Office Manager at 503-540-0288. ***You will not be penalized for filing a complaint.***

Liberty House
375 Taylor Street NE
Salem, OR 97301

Benefits and Risks of Treatment

Counseling is a collaborative process designed to help you identify the concerns that brought you to therapy, develop strategies to address these concerns, and assist you in finding resolution to your concerns. This process involves sharing personal information with your counselor that can, at times, be very sensitive or even distressing. Thus, it is not uncommon for clients to feel anxious about counseling or become upset during a session when something difficult has been shared.

The first session can be especially difficult as you are asked a number of questions related to your personal history and life experiences. This information gathering is crucial to the counseling process and is designed to identify concerns, the factors that contribute to those concerns, and treatment goals.

Counseling can carry both benefits and risks. Often counseling can lead to a significant reduction in feelings of distress, improvement in relationships, and/or resolution of specific issues. However, there are no guarantees for a "cure" or improvement of any condition

There are many factors that affect the counseling process. Those factors are both internal and external and may include lack of support system, reluctance to engage in the counseling process, or inability to attend consistently. If you believe that something will interfere with the counseling process, you are encouraged to talk with your therapist about this to problem-solve. In addition, counseling may include the risk of experiencing uncomfortable feelings (i.e. sadness, guilt, anxiety, anger…) or discussing unpleasant aspects of your life. Sometimes these uncomfortable feelings and memories associated with them lead to increased struggles in daily life initially. However, as treatment progresses, you will ideally experience improved ability to cope with difficult feelings and situations.

If you are concerned that treatment is not progressing adequately or causing more harm than good, you are encouraged to speak with your therapist about this. There will be no retribution for sharing your treatment concerns. Ultimately, it is our hope that you will find the benefits to counseling far outweigh any risks and that this will be a healing experience for your child and family.