Please print, sign and date both sides.

HIPPA – NOTICE OF PRIVACY PRACTICES: Effective on 11/01/2019.

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.

Our Legal Duty - By law I am required to: 1. Insure that your PHI is kept private. 2. Give you notice describing our legal duties, privacy practices, and your rights regarding your medical information. 3. Also, we have the right to: 1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. 2. However, before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

II. YOUR PHI:. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Written authorization you provide may be revoked at any time by writing to us. **A. Uses and Disclosures Related to Treatment, Payment**, **or Health Care Operations Do Not Require Your Prior Written Consent.** I may use and disclose your PHI without your consent for the following reasons: For treatment. as well as for billing purposes, including office staff, Insurance Providers, business associates, etc. **B. Other disclosures**. Examples: Your consent isn't required if you need emergency treatment, provided that I attempt to get your consent after treatment is rendered. I may use and/or disclose your PHI without your consent or authorization: When disclosure is required by federal, state, or local law; or, for law enforcement or persons to prevent or mitigate a serious threat to the health or safety of a person, or property and for Child, Elder/Dependent Abuse and Neglect in accordance with California Mandated Reporting.

III. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI: **A. The Right to See and Get Copies of Your PHI**, request must be in writing, response time is within 30. You may be given a summery instead or requests may be denied, but reasons for the denial will be given in writing. You can ask that denial be reviewed. Copies of your PHI are $0.50 per page. **B. The Right to Get a List of the Disclosures I Have Made within 60 days of request,** disclosure records will be held for six years and do not include Law enforcement agencies or items where you have already given consent. **C. The Right to Amend Your PHI**. It is your right to request that I correct information or add the missing information. Your request and the reason for the request must be made in writing. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me.

IV. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES: Please file a complaint with Nick Vetter, MFT at 10646 Zelzah Ave Suite 207, Granada Hills, CA 91344, or, send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201.

V. NPP (NOTICE OF PRIVACY PRACTICES): must contain a statement indicating that you have the right to be notified in case of a breach of unsecured PHI.

_____ _____Date: _____/_____/_____

Print Name Client Signature

_____ _____Date: _____/_____/_____

Print Name Client Signature

Disclosure Statement & Agreement For Services

Introduction: Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding it. **Therapist:** Your therapist is Nick Vetter a: Licensed Marriage and Family Therapist #48867, with more than 15 years of experience working with couples, and individuals. The name of this practice is: Vetter Marriage and Family Therapy.

Fees for non-Insurance Clients (subject to change with 30 day notice to clients) $75.00 per 50 minute individual therapy session; Fees or Insurance co-payment are payable at the beginning of each session. In the event that your insurer decides to stop paying for your sessions, you agree to pay the full session amount listed above. If you are unable to pay for your therapy, inform your therapist, and He or She will help you to consider other options available at that time. **Appointment Scheduling and Cancellation Policies: Please notify your therapist at least 24 hrs. in advance of your appointment when cancelling. If you do not call 24 hrs in advance of the session for cancellation you will be given a warning the first time, the second time you will be billed for the full amount of the session. If you are paying with your insurance the policy is the same your therapist cannot bill your insurance company for missed sessions. Saying yes to you means saying no to someone else for that time slot.**

Confidentiality: All communications between you and anyone in therapy with you, together with your therapist will be held in strict confidence unless you or all person(s) who participated in the treatment with you provide their written authorization to release such information. **Your therapist utilizes a "no-secrets" policy when conducting family or marital/couples therapy i.e, he will encourage all parties to share their information with other parties in the therapy. There are exceptions to confidentiality**; e.g., therapists are required to report instances of suspected child, elder abuse, or dependent adult abuse, serious harm/danger to self, others, or property to the authorities. **Minors and Confidentiality:** Communications between therapists and patients who are minors (under age18) are confidential. However, parents and other guardians provide authorization for a child's treatment consequently, your therapist may discuss the treatment of a minor patient with the parent or legal caretaker.

Therapist Availability/Emergencies: Telephone sessions between office visits are generally not available. For emergencies please call 911. You may leave a message for your therapist at any time on his/her confidential voicemail. (818) 835-0779.

About the Therapy Process: It is your therapist's intention to provide services that will assist you in reaching your goals based upon the information that you provide. **You have the right to agree or disagree with your therapist's recommendations**. **Your therapist is unable to guarantee a specific outcome or result**. **If referred by an insurance provider please be aware that treatment is linked to a Mental Health Diagnosis that will become a part of your medical record. Termination of Therapy*: You may discontinue therapy at any time*** If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives.

When receiving therapy/counseling/coaching in person or Tele-Health Video Chat Remote, you agree not to record video, audio, screenshots or photos of your therapist or from your sessions in accordance with HIPAA (Health Insurance Portability and Accountability Act of 1996) a United States legislation that provides data privacy and security provisions for safeguarding medical information. All such activity is strictly prohibited and will result in immediate termination of services rendered by this provider.

Having read the above document, I or we sign below in agreement and give my or our consent for therapy services with Vetter Marriage and Family Therapy.

_____ _____Date: _____/_____/_____
Print Name Client Signature

_____ _____Date: _____/_____/_____
Print Name Client Signature