

# **Guiding Empathy Inc.**

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7755 Center Avenue, Ste 1100, Office 1118  
Huntington Beach, CA 92647

## **NOTICE OF PRIVACY PRACTICES**

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 Duty to Safeguard Your Protected Health Information**

Protected Health Information (PHI) refers to information in your health record that could identify you. It is individually identifiable information about your past, present, or future health or condition, the provision of healthcare to you, or payment for the health care. Examples of PHI include your name, address, birth date, age, phone number, diagnosis, medical records, and billing records.

We are required by applicable federal and state law to maintain the privacy of your protected health information, and to give you this Notice of Privacy Practices that describes our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notification takes effect January 1, 2017 and will remain in effect until replaced.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice of Privacy Practices at any time. For more information about our privacy practices or additional copies of this Notice, contact our office.

### **Other Uses and Disclosures Without Your Authorization**

We may be required or permitted to disclose your personal health information (e.g., your mental health records) without your written authorization. The following circumstances are examples of when such disclosures may or will be made:

1. If disclosure is compelled by a court pursuant to an order of that court.
2. If disclosure is compelled by a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority.
3. If disclosure is compelled by a party to a proceeding before a court or administrative agency pursuant to a subpoena, subpoena duces tecum (e.g., a subpoena for mental health records), notice to appear, or any provision authorizing discovery in a proceeding before a court or administrative agency.

4. If disclosure is compelled by a board, commission, or administrative agency pursuant to an investigative subpoena issued pursuant to its lawful authority.
5. If disclosure is compelled by an arbitrator or arbitration panel, when arbitration is lawfully requested by either party, pursuant to a subpoena duces tecum (e.g., a subpoena for mental health records), or any other provision authorizing discovery in a proceeding before an arbitrator or arbitration panel.
6. If disclosure is compelled by a search warrant lawfully issued to a governmental law enforcement agency.
7. If disclosure is compelled by the patient or the patient's representative pursuant to Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the California Health and Safety Code or by corresponding federal statutes or regulations (e.g., the federal "Privacy Rule," which requires this Notice).
8. If disclosure is compelled or by the California Child Abuse and Neglect Reporting Act (for example, if I have a reasonable suspicion of child abuse or neglect).
9. If disclosure is compelled by the California Elder/Dependent Adult Abuse Reporting Law (for example, if I have a reasonable suspicion of elder abuse or dependent adult abuse).
10. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or to the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
11. If disclosure is compelled or permitted by the fact that you tell me of a serious threat (imminent) of physical violence to be committed by you against a reasonably identifiable victim or victims.
12. If disclosure is compelled or permitted, in the event of your death, to the coroner in order to determine the cause of your death.
13. As indicated above, we are permitted to contact you without your prior authorization to provide appointment reminders or information about alternatives or other health-related benefits and services that may be of interest to you. Be sure to let us know where and by what means (e.g., telephone, letter, email, fax) you may be contacted.
14. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law, including but limited to, audits, criminal or civil investigations, or licensure or disciplinary actions. The California Board of Behavioral Sciences, who license marriage and family therapists, is an example of a health oversight agency.
15. If disclosure is compelled by the U. S. Secretary of Health and Human Services to investigate or determine my compliance with privacy requirements under the federal regulations (the "Privacy Rule").
16. If disclosure is otherwise specifically required by law.

PLEASE NOTE: The above list is not an exhaustive list, but informs you of most circumstances when disclosures without your written authorization may be made. Other uses and disclosures will generally (but not always) be made only with your written authorization, even though federal privacy regulations or state law may allow additional uses or disclosures without your written authorization. Uses or disclosures made with your written authorization will be limited in scope to the information specified in the authorization form, which must identify the information

"in a specific and meaningful fashion." You may revoke your written authorization at any time, provided that the revocation is in writing and except to the extent that I have taken action in reliance on your written authorization. Your right to revoke an authorization is also limited if the authorization was obtained as a condition of obtaining insurance coverage for you. If California law protects your confidentiality or privacy more than the federal "Privacy Rule" does, or if California law gives you greater rights than the federal rule does with respect to access to your records, we will abide by California law. In general, uses or disclosures by us of your personal health information (without your authorization) will be limited to the minimum necessary to accomplish the intended purpose of the use or disclosure. Similarly, when we request your personal health information from another health care provider, health plan or health care clearinghouse, we will make an effort to limit the information requested to the minimum necessary to accomplish the intended purpose of the request. As mentioned above, in the section dealing with uses or disclosures for treatment purposes, the "minimum necessary" standard does not apply to disclosures to or requests by a health care provider for treatment purposes because health care providers need complete access to information in order to provide quality care.

### **Your Rights Regarding Protected Health Information**

1. You have the right to request restrictions on certain uses and disclosures of protected health information about you, such as those necessary to carry out treatment, payment, or health care operations. We are not required to agree to your requested restriction. If we do agree, we will maintain a written record of the agreed upon restriction.
2. You have the right to receive confidential communications of protected health information from us by alternative means or at alternative locations.
3. You have the right to inspect and copy protected health information about you by making a specific request to do so in writing. This right to inspect and copy is not absolute – in other words, we are permitted to deny access for specified reasons. For instance, you do not have this right of access with respect to our "psychotherapy notes." The term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical (includes mental health) record. The term excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.
4. You have the right to amend protected health information in our records by making a request to do so in a writing that provides a reason to support the requested amendment. This right to amend is not absolute – in other words, we are permitted to deny the requested amendment for specified reasons. You also have the right, subject to limitations, to provide us with a written addendum

with respect to any item or statement in your records that you believe to be incorrect or incomplete and to have the addendum become a part of your record.

5. You have the right to receive an accounting from us of the disclosures of protected health information made by me in the six years prior to the date on which the accounting is requested. As with other rights, this right is not absolute. In other words, we are permitted to deny the request for specified reasons. For instance, we do not have to account for disclosures made in order to carry out our own treatment, payment or health care operations. We also do not have to account for disclosures of protected health information that are made with your written authorization, since you have a right to receive a copy of any such authorization you might sign.
6. You have the right to obtain a paper copy of this notice from Guiding Empathy Inc. upon request.

PLEASE NOTE: In order to avoid confusion or misunderstanding, we ask that if you wish to exercise any of the rights enumerated above, that you put your request in writing and deliver or send the writing to Guiding Empathy Inc. If you wish to learn more detailed information about any of the above rights, or their limitations, please let us know. We are willing to discuss any of these matters with you.

### **Questions and Complaints**

If you want more information about our privacy practices or have questions or concerns, please contact us. We will do my best to answer your questions and to provide you with additional information.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about your access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to me and to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with me by simply providing me with a writing that specifies the manner in which you believe the violation occurred, the approximate date of such occurrence, and any details that you believe will be helpful to me. Our telephone number is 714-988-2454. We will not retaliate against you in any way for filing a complaint with Guiding Empathy Inc.

This notice first became effective on November 1, 2019.

# Guiding Empathy Inc.

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7755 Center Avenue, Ste 1100, Office 1118  
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## INFORMED CONSENT CONTRACT

**Welcome to our practice.** This agreement is intended to provide you with important information regarding our services and office policies. Please read the entire document carefully and ask your therapist any questions regarding its contents prior to signing it.

### Information about your therapist

You are free to ask questions at any time regarding your therapist's professional background, including experience, education, special interests, and professional orientation.

### Confidentiality

Therapy is both a confidential and professional relationship. What you communicate during the course of treatment is protected by legal, professional, and ethical standards. Information gathered during the course of treatment may not be released without your prior written consent. However, California Law has placed specific limits on the confidentiality of the therapeutic relationship.

According to California State Law, this Therapist and Practice has a legal obligation to breach confidentiality under the following circumstances:

1. If the therapist determines, or has reasonable cause to believe, the client is in such mental or emotional condition as to be dangerous to him/herself or to the person or property of another and the disclosure of confidential information is necessary to prevent the threatened danger. (Evidence Code 1024)
2. If a therapist knows or reasonably suspects a child is being abused or neglected. (Penal Code Section 11165)
3. If a therapist has reasonable knowledge or suspicion that a person over age 65 or a dependent adult has been physically abused. (California State Law)
4. In cases of threatened suicide, the therapist has a legal duty to take reasonable steps to prevent it. (Bellah vs. Greenson)
5. If requested by client or compelled by court.

Note: We cannot guarantee that text messaging, email, and/or electronic receipts are secure or confidential forms of communication.

### Treatment for Minors

We require that both parents or legal guardians sign to consent for treatment of a minor. We require a copy of current Custody Orders and/or proof of legal guardianship for the minor, if applicable, prior to the commencement of therapy. Please provide your therapist with a copy, either by email or fax, prior to the initial session so that our records are complete.

### Professional Consultation and Supervision

Professional consultation is an important component of a healthy therapy practice. As such, therapists regularly participate in clinical, ethical, and legal consultations with appropriate professionals, including consultation with other licensed colleagues.

Additionally, in accordance with California State Law Licensing Regulations, all pre-licensed therapists receive individual and group supervision. Therefore, confidentiality will not be maintained during consultation with the supervisor and other professional persons hired by the Practice for the purpose of staff training. (California Code of Regulations, Title 16.)

### **Notice of Privacy Practices**

The Notice of Privacy Practices provides information about how Guiding Empathy Inc. may use and disclose your protected health information. We encourage you to read it in full. The Notice of Privacy Practices is subject to change. If we change the Notice, you may obtain a revised copy from your therapist. If you have any questions about the Notice of Privacy Practices, please contact our office.

### **Emergencies**

We are unable to provide 24-hour crisis service. In the event that you are feeling unsafe or require immediate medical or mental health assistance, please be aware of the following resources:

- 911 or go to the nearest emergency room
- The OC WarmLine: 877.910.9276 or 714.991.6412
- CAT-Centralized Assessment Team: 866.830.6011
- Suicide Prevention: 877.7CRISIS/877.727.4747

### **Risks and Benefits of Therapy**

It is our intention to provide you with services that will assist you in reaching your goals. Therapy is a unique and highly individualized experience with the outcome determined by active participation inside and outside of session. Additionally, progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors. Benefits may include improvement in some aspects of your life, solving problems, or expressing feelings to an accepting person.

However, there is no guarantee that therapy will yield positive or intended results. Some risks include the possibility of experiencing some discomfort due to remembering and discussing unpleasant events, feelings, and experiences which may result in experiencing a range of emotions that may be uncomfortable at times.

### **Termination of Treatment and Complaints**

Therapy has been shown to be beneficial to those who undertake it. If at any time, you have questions or concerns regarding the services you receive, we strongly encourage you to discuss them with your therapist. If you feel that your therapist is not a good fit for you or that you may benefit by going to another therapist for various reasons, please call our office and we will be happy to reassign you to another therapist. Also, you have the right to decide to end treatment. If you are thinking about ending therapy, we encourage you to discuss it with your therapist so that we may minimize terminating treatment against medical advice. If termination of treatment is indicated, we can provide you with names of other mental health providers.

Your therapist has the right to terminate therapy due to, but not limited to, the following reasons: untimely payment of fees, failure to comply with treatment recommendations, conflict of interest, failure to participate in therapy, a client's needs are outside the therapist's scope of competence or practice, or a client is not making adequate progress in therapy.

## Acknowledgement of Informed Consent Contract

*I have read the Informed Consent Contract and/or Telemedicine Informed Consent Contract fully and completely; I have discussed any questions I had about the information with my therapist, and I understand the information. I apply for and consent to my therapy treatment (or the treatment for my child) and I agree to the terms and conditions detailed above.*

Please check one:       Accept a copy of Contract       Decline a copy of Contract

\_\_\_\_\_  
Signature (Client)

\_\_\_\_\_  
Date

\_\_\_\_\_  
If client is a minor, signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
If client is a minor, signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date

As a minor, I give the therapist or Practice permission to share information with my parent or guardian as is deemed appropriate throughout the treatment process.

\_\_\_\_\_  
Signature (Minor)

\_\_\_\_\_  
Date

## Acknowledgment of Receipt of Notice of Privacy Practices

*By signing this form, I acknowledge that I have reviewed the Notice of Privacy Practices (NPP) of the office of Guiding Empathy Inc.*

Please check one:       Accept a copy of NPP       Decline a copy of NPP

\_\_\_\_\_  
Signature (client/parent or guardian)

\_\_\_\_\_  
Date

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### For Office Use Only

#### Inability to Obtain Acknowledgment of Receipt of Notice of Privacy Practices

Guiding Empathy Inc. made good faith attempts to obtain written acknowledgement of receipt of his or her Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign       An emergency situation prevented him/her  
 Other (specify) \_\_\_\_\_      from reviewing the NPP

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date

Consent 3 of 3