

Sankofa Sex Therapy, LLC

De-Andrea Blaylock-Johnson, MSW, LCSW

10176 Corporate Square Drive Suite 100-S St. Louis, MO 63132 314-877-8510

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.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the NASW *Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities, including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Updated 7/15/2015

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule. We may disclose, as needed, your PHI to the Children's Division in the instance of abuse or neglect. PHI may be disclosed in the occurrence of judicial proceedings, medical or mental health emergencies, law enforcement, national security, and public health. In addition, PHI may be released for the sake of public safety for the therapist to comply with duty to warn if a threat to another person is made.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to this office at:

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St. Louis, MO 63132

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting on certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with De-Andrea Blaylock-Johnson or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, DC 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is July 15, 2015.

Updated 7/15/2015

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THERAPIST – PATIENT SERVICES AGREEMENT

This Agreement contains important information about my professional services and business policies. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. In addition, The Health Insurance Portability and Accountability Act, a federal law, requires that I provide you with a Notice of Privacy practices and that I obtain your signature acknowledging that I have provided you with this information. Those Privacy Practices appear at the end of this document and constitute a part of this agreement and you will receive a copy at the end of our first session.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily defined, but varies depending upon the personality of the therapist and the particular issues on which you intend to focus during this work. There are many different methods I use, but it will always require your active participation. In order for therapy to be successful, it is important that you follow up with homework and work on things discussed during sessions.

Psychotherapy can yield many benefits, but there are some risks as well. Since therapy often involves discussion unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. However, my hope is that our therapeutic work can lead to better relationships, solutions to specific problems, and stress reduction. There are no guarantees of what you will experience.

If you have questions about my specific methods, please feel free to discuss them as they arise.

SESSIONS

All sessions are either 50 minutes or 90 minutes long. If you are late for a session, that time is lost. If I am late for a session, we will extend the session if you are willing to do so or we will make other arrangements by mutual consent.

Since a time slot is reserved for you that cannot be offered to anyone else, **you will be charged for all missed appointments not cancelled 24 hours in advance.** In the case of inclement weather and school closings, I will be in the office unless I call you. If you need to cancel, I will not charge if you call before 12pm. If you call after 12pm, I will charge the usual fee.

PAYMENT AND FEES

Current fees are as follows: \$80 for 50-minute session
 \$120 for 90-minute session

Updated 7/15/2015

Additional time is billed at \$20 per quarter hour. These fees are also billed for services such as telephone calls not related to scheduling, special reports, and collateral consultation. You are responsible for payments whether they are requested by you or necessitated by some other process. Please note that I am **not a Medicare provider and therefore my services are not covered under Medicare**. I do not currently accept payment for services from that program or any other HMO, managed care, or insurance companies.

Fees are reviewed in January of each year. When I become fully certified through AASECT, the fees will increase to reflect that. However, you will be informed of such an increase.

You will be expected to pay for each session at the time of service. If your account has not been paid for more than 60 days and arrangement for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information released regarding your treatment would be your name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

CONTACTING ME

I am not often immediately available by telephone. However, I am usually in the office Monday evenings between 6pm and 9pm. I will not answer the phone while in session with another client. However, my phone is answered by voicemail that I monitor frequently. I will make every effort to return your call within 24 hours with the exception of weekends and holidays. If you are unable to reach me and have an emergency, please call 911 or go to your nearest emergency room. If I will be unavailable for an extended period of time, I will provide you with the name of a colleague to contact if necessary.

You may also contact me via email. However, please note that it is not considered confidential and may be recovered by other parties at any time. **You may lose your right to confidentiality by corresponding with me by email and by receiving correspondence from me by email.**

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that disclosure is reasonably likely to endanger the life or physical safety of you or another person, you may examine and/or receive a copy of your Clinical Record if requested in writing. In those situations, you have a right to a summary and to have your record sent to another mental health provider. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health professional so you can discuss the contents. Please refer to the Notice of Privacy Practices for further details.

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Your signature below indicated that you have received a copy and read this Agreement (dated 7/15/2015) and agree to abide by its terms during our professional relationship.

Client or Responsible Party Signature

Date

Printed Name

Address for Billing and Correspondence

Phone number(s)

*This authorizes me to contact you at this number(s) and I will leave my first name and a number for return contacts from you. This includes leaving messages on answering machines or voice mail. Please **DO NOT** include numbers where you prefer not to be contacted or have messages left for you.*

Email Address

Only by previous agreement with clinician

Signature regarding approval of receiving email from clinician knowing limits of confidentiality