All Parties Please print, sign and date both sides.

HIPPA – NOTICE OF PRIVACY PRACTICES: Effective on 9.21.2022.

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 - 1. Insure the privacy of your PHI. 2. Notify you of our legal duties, privacy practices, and your rights regarding your medical information. 3. Also, we have the right to: Change our privacy practices and the terms of this notice at any time as permitted by law.

II. YOUR PHI:. We will not use or disclose your medical information without your written authorization, unless compelled by law. You may revoke your authorization in writing. **A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.** I may disclose your PHI without your consent in the case of: treatment and billing purposes. **B. Other disclosures**. Examples: Your consent isn't required if you need emergency treatment, but must attempt to get your consent afterward. I may use and/or disclose your PHI without your consent or authorization: When compelled by law enforcement to mitigate against serious threat or suspicion thereof, to the health or safety of a person, or property in accordance with California Mandated Reporting.

III. 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,** all records will be held for 7 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. Your request and the reason for the request must be made in writing. I may deny your request, in writing, if: 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 speak with or text/email me at 818-835-0779, nv4mft@proton.me, or written correspondence to my office at: Office address: 9659 Balboa Blvd. Northridge, CA 91325. If you do not wish to contact me directly to resolve the issue, please send a written complaint concerning: **Nick Vetter, LMFT lic.48867** to either your medical insurance company, or if paying cash: to the Board of Behavioral Sciences, 1625 North Market Blvd., Suite S-200, Sacramento, CA 95834, or electronically at: https://www.breeze.ca.gov/datamart/mainMenu.do, www.bbs.ca.gov, or by calling (916) 574-7830. This notice complies with AB 630, Chapter 229, Statutes of 2019 to provide this information to clients who receive psychotherapy.

V. NPP (NOTICE OF PRIVACY PRACTICES): You have the right to be notified in case of a breach of your PHI.

_____ _____Date: _____/_____/_____

Print Name Signature

_____ _____Date: _____/_____/_____

Print Name Signature

Disclosure Statement & Agreement For Services

Introduction: Please read the entire document and 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**. < If you want therapy for resolution of any legal, Department of Child Family Services, Corrections or any other court mandated or related reason, I cannot take your case and you are advised to seek forensic services elsewhere. This therapist does not provide correspondence or opinions to any party outside of therapy. >**

Cash fee (subject to change with 30 day notice to client/s), $75.00 per 50 minute individual therapy session; vs Insurance with co-payment or payment toward meeting a deductible (please call your insurance company to determine amount), is payable at the beginning of each session. **If your insurer stops payment for your sessions, you agree to pay the full session amount listed above**. Appointment Scheduling and Cancellation Policies: Please notify your therapist at least 24 hrs. in advance of your appointment when cancelling. If you do not you will be given a courtesy warning the first time, the second time you will be billed for the full amount of the session.

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. There are exceptions to confidentiality; e.g., therapists are required to report instances of suspicion concerning, serious harm/danger to self, others, or property to local authorities. Your therapist utilizes a "no-secrets" policy, so that all parties share their information with other parties in the therapy or therapy may be terminated.

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. You have the right to agree or disagree with your therapist's recommendations. Your therapist is unable to guarantee a specific outcome. When using insurance 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. Moreover, your Therapist/Coach/Counselor may choose to terminate your treatment and refer you to another service provider, if you might be better served elsewhere.

For Telehealth/Virtual Therapy or Talk Therapy/Coaching/Counseling in person, you agree not to record video, audio, screenshots or photos of your therapist /sessions, in accordance with HIPAA (Health Insurance Portability and Accountability Act of 1996) 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. Having read the above document, **I agree to the aforementioned stipulations in this document and sign to give consent for therapy services Nick Vetter, LMFT.**

_____ _____**Date:** _____/_____/_____

Print Name **Signature**

_____ _____**Date**: _____/_____/_____

Print Name **Signature**