# Karla Benzl, M.D.

**26131 Marguerite Pkwy Suite D/ Mission Viejo, CA 92692**
**Email: DrBenzl@karlabenzlmd.com**
**Phone: (949) 763-4040**
**Fax: (814) 402-7131**

## 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.

### My Pledge to Safeguard Your Protected Health Information

I am committed to protecting your medical information. Any record of care created by me regarding your treatment is used for the sole purpose of your treatment. This notice will inform you about the ways I use your protected health information. It describes your rights and my obligations to protect medical information. **Protected Health Information (PHI)** refers to any information in your medical chart that could potentially identify you. It includes information about your past, present or future health, as well as what treatments were provided to you, or payments for care. Examples include but are not limited to: name, date of birth, gender, address, phone number, diagnosis. I am required by state and federal law to maintain the security and privacy of your PHI, and to clearly outline my privacy practices, legal obligations, and rights.

### My responsibilities:

1) I am required by law to maintain the privacy and security of your PHI
2) I will inform you promptly if a breach occurs that may have compromised the privacy or security of your information
3) I must abide by the terms described within the Notice of Privacy Practice while in effect. These are outlined in this Notice of Privacy Practices. This notice has been effective since August 27, 2018.
4) I will not use or share your information other than described within the Notice of Privacy Practice unless you tell me I can in writing. You can retract consent at any time by noting your request in writing.

**Your Rights:** When it comes to medical information, you have certain rights.

1) Obtain an electronic or paper copy of your medical record. This can be done at any time. Ask me how to do this. I will provide a copy or a summary of your health information, usually within 30 days of your request. I may charge a reasonable, cost-based fee as outline in my policies.
2) Ask me to correct the medical record via amendment or addendum. You can ask me to correct health information that you think is inaccurate or incomplete. Ask me how to do this.
3) Request confidential communications. You can ask me to contact you in a specific way (home or office phone) or to send mail to a different address.

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4) Ask me to limit what I use or share. You can ask me to share certain health information for treatment, payment, or the operations of my practice. I am not required to agree to your request, and I may decline if it would affect your care.
5) Get a list of those with whom I have shared information. You can ask me for a list of the times I have shared your health information for six years prior to the date you ask, whom I shared it with, and why. I will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked me to make). I will provide one accounting per year for free but will charge a reasonable, cost-based fee if you request another within 12 months.
6) Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.
7) Choose someone to act for you. If you have someone who is your medical power of attorney or legal guardian, that person can exercise your rights and make choices about your health information.
8) File a complaint if you feel your rights have been violated. You can complain if you feel I have violated your rights by contacting me using my contact information above. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave., S.W., Washington, D.C. 20201, calling (877)696-6775 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. I will not retaliate against you for filing a complaint.

**Your Choices.** For certain health information, you can tell me your choices about what I share. If you have a clear preference for how I share your information in situations described below, tell me what you want me to do and I will follow your instructions.

1) In these cases, you have the right and the choice to tell me to: Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. If you are not able to tell me your preference, for example, if you are unconscious, I will go ahead and share your information if I believe it is in your best interest. I may also share your information when needed to lessen a serious and imminent threat to health or safety.
2) In these cases, I never share your information unless you give me written permission: Marketing purposes, sale of your information, most sharing of psychotherapy notes. In the case of fundraising, I may contact you for fundraising efforts, but you can tell me not to contact you again.
3) I may disclose your PHI in the following circumstances if I inform you about the disclosure in advance and you do not object: To notify or assist in the notification of a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, I will ask you for permission prior to the disclosure. In the event of your incapacity or an emergency situation, and you are not able to state your wishes, then I will disclose PHI in accordance with your prior expressed wishes, when disclosure is determined to be in your best

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interest. In these circumstances, I will only disclose the information that is relevant to the person's involvement in your healthcare.

## How I May Use Your Protected Health Information:

1) Uses and/or disclosures of PHI for treatment, payment, and health care operations that do not require authorization
    a. Treatment:
       I can use your PHI and share it with other professionals who are treating you. This includes but is not limited to consultations and referrals between one or more providers. I may disclose medical information about you to other physicians, nurses, technicians, medical students or other healthcare personnel that are involved in your care.
    b. Run my organization:
       I can use and share your health information to run my practice, improve your care, and contact you when necessary. For example, the Privacy Rule allows me to contact you via phone/voicemail to schedule appointments and to leave appointment reminders, unless you specifically request another form of communication.
    c. Bill for services:
       I can use and share your health information to bill and get payment from health plans or other entities. For example, a medical insurance company may contact a provider on your behalf to facilitate your access to mental health treatment. Your health insurance may need to determine your eligibility and coverage for mental health services.
2) Uses and/or disclosures of PHI that require authorization:
    a. You may permit me via written consent to use your health information or disclose it to anyone for any purpose. You may revoke your written consent anytime via writing. Any use/disclosure that took place while the authorization was in effect will not be affected by your revocation.
    b. Written authorization is also required before releasing your psychotherapy notes.
3) Other Uses and/or Disclosures of PHI that Do Not Require Authorization or Consent: HIPAA Privacy Rule provides that I may use/disclose your PHI without your authorization in several different circumstances outlined below. These disclosures are usually to serve the public good. For more information, please see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html
    a. To avert serious threat to health or safety: I may disclose your PHI when necessary to prevent or lesson a serious and imminent threat to your health and safety or the health and safety of the public or another person. See below under **"Confidentiality"** for more information.
    b. Abuse, neglect, domestic violence: I may disclose PHI to appropriate authorities if I have reasonable suspicion you are a possible victim of abuse, neglect, domestic violence or other

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crimes. Whenever I , in my professional capacity, have knowledge of or observe child abuse or neglect, I must immediately report to the police/sheriff's department, county probation department, child protective services, or county welfare department. If I have knowledge of or reasonable suspicion that a child has suffered psychological suffering as a result of verbal abuse, or that his/her emotional well-being is endangered in any other way, I may report this to the authorities listed above.

c. Organ or Tissue Donation: If you are an organ donor, I may disclose your medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank.
d. Military and Veterans: If you are or were a member of the armed forces, I may release medical information about you to the military command authorities as authorized or required by law. I may also release medical information about foreign military personnel to the appropriate military authority as authorized or required by law.
e. Workers' Compensation: I may use/disclose medical information about you for Workers' Compensation or similar programs as authorized or required by law. These programs provide benefits for work-related injuries.
f. Public Health Concerns: I may disclose information about you for public health purposes such as controlling the spread of disease or injury, public health surveillance, reporting adverse events to foods, medications, supplements. Other examples include notifying persons of recalls, or notifying persons who may have been exposed to disease or may be at risk of contracting disease.
g. Health Oversight Activities: I may disclose your PHI to governmental, licensing, auditing, and accrediting agencies as authorized or required by law.
h. Judicial and administrative proceedings: I may disclose PHI to courts, attorneys and court employees in the course of conservatorship and certain other judicial or administrative proceedings.
i. Lawsuits and other legal actions: I may disclose PHI in connection with lawsuits or other legal proceedings, in response to a subpoena, discovery request, warrant, summons or other lawful process.
j. Law enforcement: I may disclose PHI for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death suspected to be the result of criminal conduct.
k. Coroners, medical examiners, funeral directors: I may disclose information to a coroner or medical examiner if needed to identity a deceased person or determine the cause of death.

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l. National Security and Intelligence Activities: I may disclose PHI as required by law to federal officials for intelligence, counterintelligence, and other national security activities.
m. Protective Services for the President and Others: I may disclose PHI to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons or foreign heads of states.
n. Inmates: If you are an inmate of a correctional institution or under the custody of law enforcement officials, I may disclose your PHI to the correctional institution as authorized or required by law.

**Confidentiality:** The security of client information is of utmost importance to Dr. Benzl, and she is bound by law to protect client confidentiality. Any disclosure of treatment information will require written and signed consent. Basic information of your treatment may be disclosed to your medical insurance company for matters of prior authorizations or billing. In addition to the circumstances mentioned above, there are few exceptions to this confidentiality, where disclosure is mandated by law. These include:

1. Any threat of harm to yourself. I am required to seek immediate hospitalization and will likely seek the aid of family or friends to do so. At times, law enforcement or emergency services will assist in the process of transportation to the hospital, if hospitalization is against the will of a person who is a threat to him or herself.
2. Any threat of harm to others. I am required by law to take protective action including reporting the threat to the potential victim, notifying law enforcement, and seeking hospitalization.
3. Suspected cases of child abuse require mandatory reporting to Child Protective Services as described above.
4. In situations where dementia, epilepsy, or other cognitive dysfunction impair safe operation of a motor vehicle, DMV must be notified.
5. If mental illness impairs your ability to provide your own basic needs, such as food, clothing, or shelter, Dr. Benzl is mandated to disclose this information and seek hospitalization for you.

These situations occur rarely. Dr. Benzl will do her best to discuss any of the above situations with you prior to taking action. At times, she will seek consultation from other clinicians, without providing your clinical identity.

Signature of Patient: _____ Date: _____

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## Acknowledgement of Receipt of Notice of Privacy Practices

**You have the right to refuse this acknowledgement**

I, _____, have received a copy of Dr. Benzl's Notice of Privacy Practices.

Signature of Patient: _____Date: _____

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FOR OFFICE USE ONLY

Dr. Benzl attempted to obtain acknowledgement of Notice of Privacy Practices, however, acknowledgement could not be obtained for the following reasons.

_____ Individual refused to sign

_____Emergency Situation prevented signature of acknowledgement

_____Other:_____
_____

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Please read carefully. Please initial each page and sign the last page.

**SERVICES OFFERED**

1. **Psychotherapy:**
   Psychotherapy, or talk therapy, is an evidence-based treatment for many emotional complaints. Sessions occur weekly or every other week, for 45-50 minutes. Psychotherapy does require motivation, commitment, and work from both parties to ensure an effective therapeutic relationship. It can help improve interpersonal relationships, reduce stress, increase emotional awareness, and deepen insight. Clients will have varying success with this type of treatment, depending on the severity of their symptoms, capacity for self-reflection, and motivation to apply what is learned within therapy to real life. The process of psychotherapy can bring forth uncomfortable emotions or painful memories. These experiences should be brought to the attention of the therapist in session. Please note that therapy is most effective when the client and therapist are a good fit. If at any time, the match between client and therapist does not feel right, I encourage both parties to discuss and to consider referrals. At times, psychotherapy alone is an effective treatment. Other times, the combination of therapy and medication management will yield the best results.
2. **Medication Management:**
   Medications may be indicated when symptoms are severe enough to impair ability to function at work or home, or attend to personal needs. Certain medications are to be taken daily, and will require a taper upon discontinuation. Other medications, such as sleep medications or anti-anxiety medications, will be prescribed for "as needed use." Side effects will be routinely assessed. The need for ongoing medication will also be routinely assessed. Again, discontinuation symptoms can occur when abruptly stopping psychiatric medications, so please address any plans to change/stop medications with Dr. Benzl.
3. **Video appointments:**
   Video appointments may be offered for psychotherapy and/or medication management, when appropriate. These appointments will be conducted through a HIPAA compliant application called VSee. Clients must have working internet, a webcam, and privacy to effectively conduct these appointments. If technical issues are a routine problem, Dr. Benzl will reserve the right to discontinue video appointments.

**APPOINTMENT FREQUENCY**

I understand that Dr. Benzl and I will agree together on a reasonable frequency of sessions. It is expected that I maintain this frequency of visits in order to facilitate safe and effective treatment.

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**CANCELLATIONS**

I understand that appointment cancellations must be made within 48-business hours. If a cancellation is not made within that time, or if the appointment is missed without notification, I will be charged $100.00. Dr. Benzl may offer to waive the penalty charge if the missed session can be rescheduled for another time during the same week, but this will be up to her discretion and availability. I understand that in the event of a missed or cancelled appointment, medications may or may not be refilled depending on the level of clinical supervision needed. Appointments cancelled for true medical or family emergencies will be honored without penalty.

**OFFICE HOURS**

Office hours are held Mondays, Tuesdays, Thursdays, and Fridays, between 9:00am and 4:30pm. Urgent appointments may be offered outside of these office hours.

**EMERGENCY CONTACT**

I agree to call Dr. Benzl immediately regarding any urgent medical or psychiatric issue, including significant side effects of medications or significant changes in mood or behavior. If the situation becomes unsafe, such as the development of suicidal plan or intent, I will immediately call 911 or seek care at the nearest emergency room, whether or not I have already spoken with Dr. Benzl.

**NON-EMERGENCY CONTACT**

I understand that I will call or email Dr. Benzl for any matters outside of appointments, at 949-763-4040 or at drbenzl@karlabenzlmd.com. Dr. Benzl will check her voicemail frequently and will attend to any **urgent** matters promptly. I understand that she will make an effort to respond within one business day for **non-urgent** matters. Non-urgent matters will not be attended to on weekends or evenings. I understand that Dr. Benzl is generally not available to answer texts, phone calls, or emails outside of business hours.

**CONFIDENTIALITY OF ELECTRONIC COMMUNICATION**

At this time, Dr. Benzl has a HIPAA compliant email (drbenzl@karlabenzlmd.com) as well as HIPAA compliant voicemail at 949-763-4040. I will reserve their use for managing appointments or requesting direct communication from Dr. Benzl. For my convenience, I can choose to email Dr. Benzl reports for her review. However, I understand that she will not reply with clinically sensitive information. I will allow Dr. Benzl to leave messages on my voicemail unless I specifically request otherwise, with the understanding that every effort will be made to maintain confidentiality.

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**PRIVACY PRACTICES**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

**INSURANCE BENEFITS**

I understand that Dr. Benzl only accepts Anthem Blue Cross at this time. Patients are expected to call Member Benefits to clarify deductible amounts prior to scheduling with Dr. Benzl. Deductibles and copays will be applied to the card on file, unless otherwise agreed upon.

If you are on a PPO plan other than Anthem Blue Cross, Dr. Benzl is considered an Out-of-Network provider. Dr. Benzl will provide a superbilll at your request to submit for reimbursement to your insurance company. Please note that many insurance companies have limitations on the number and frequency of visits, and the type of medications covered. Occasionally, certain forms of treatment, or large numbers of sessions require a prior authorization. If this is the case, Dr. Benzl may need to provide information about your diagnosis, history, and treatment plan to your insurance company. Once this information is provided, it will be subject to the privacy policies of the insurance provider.

**FEE FOR SERVICE**

If you are paying out of pocket for sessions, and do not submit to insurance for reimbursement, Dr. Benzl will provide a Good Faith Estimate of appointments. This will be uploaded to the patient portal. I understand that I am responsible for payment in full for service. Payment is due at the time of service. Fees will be agreed upon in advance of the session. Fees for 30 minute medication management appointments are $190. Fees for 45-50 mins psychotherapy appointments and medication management are $250. Psychotherapy only appointments are 50 mins and $250 a session.

Miscellaneous services, such a filing forms, telephone correspondence, prior authorizations, court hearings, etc, requiring more than ten minutes of Dr. Benzl's time will cost $40.00 per ten minute interval. Fees may be subject to change. If Dr. Benzl's fees increase, you will be provided a thirty day notice.

**Administrative Fees**

Prior authorizations $30

Controlled substance requests between appointments $20

EDD paperwork $15

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FMLA paperwork $15

Medical Letters $20

Other Forms- $40 per 10 mins of time

No show fee $100, resuming 48 business hour notice, however, if there are appointments available within the same week, this fee will be waived. Also, if there is a medical or family emergency, this will be waived. I cannot waive work emergencies or forgotten appointments.

**PAYMENTS**

Payments are due at the time of service. I accept major credit cards, personal check, or cash.

**MEDICAL RECORDS**

Dr. Benzl is required, by law, to keep complete medical records. Medical records will be kept electronically via a HIPAA compliant service to protect patient privacy. Any written/paper records will be uploaded to the medical chart, and then shredded. The computer Dr. Benzl uses to access medical records will be used solely for the purpose of her private practice and will be safeguarded appropriately. You are entitled to view your medical records at any time, unless Dr. Benzl feels your emotional or physical well-being will be jeopardized. If you wish to review your medical records, Dr. Benzl recommends that you review them with her to decrease any confusion or misinterpretation of clinical language. Time spent collecting, printing, copying, or summarizing the medical record will be charged the appropriate fee (see above).

**MY PRACTICE**

Dr. Benzl shares an office with other mental health professionals, however, she is in no way part of a group practice. Her medical records are kept secure, and separate from theirs. Any collaboration of care with other mental health providers will require written consent.

**CONFIDENTIALITY**

The security of client information is of utmost importance to Dr. Benzl, and she is bound by law to protect client confidentiality. Any disclosure of treatment information will require written and signed consent. Basic information of your treatment may be disclosed to your medical insurance company for matters of prior authorizations or billing. There are few exceptions to this confidentiality, where disclosure is mandated by law. These include:

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6. Any threat of harm to yourself. I am required to seek immediate hospitalization and will likely seek the aid of family or friends to do so. At times, law enforcement or emergency services will assist in the process of transportation to the hospital, if hospitalization is against the will of a person who is a threat to him or herself.
7. Any threat of harm to others. I am required by law to take protective action including reporting the threat to the potential victim, notifying law enforcement, and seeking hospitalization.
8. Suspected cases of child abuse require mandatory reporting to Child Protective Services.
9. In situations where dementia, epilepsy, or other cognitive dysfunction impair safe operation of a motor vehicle, DMV must be notified.
10. If mental illness impairs your ability to provide your own basic needs, such as food, clothing, or shelter, Dr. Benzl to disclose this information and seek hospitalization for you.

These situations occur rarely. Dr. Benzl will do her best to discuss any of the above situations with you prior to taking action. At times, she will seek consultation from other clinicians, without providing your clinical identity.

**CONSENT FOR TREATMENT**

I, the undersigned patient, consent to evaluation and medically necessary treatment by Karla Benzl, M.D. I understand that I have the right to be informed of and participate in the selection of treatment modalities. I understand I can terminate consent for treatment at any time. I also understand that Dr. Benzl may terminate consent for treatment at any time. Potential reasons include misusing psychiatric medications or failing to meet the expectations for payment and session attendance. Multiple missed appointments for non-emergent issues will be considered grounds for termination. If need for termination of treatment should occur, Dr. Benzl will discuss the reasons with me and will assist me in finding an alternative treatment provider.

Signature of Patient: _____ Date: _____

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**CONSENT TO USE TELEMEDICINE**

I, _____, am physically located in _____. At the beginning of each telemedicine session, I will help Dr. Dr. Karla Benzl to complete a check- in to **assess the suitability of using telemedicine services by verifying my full name, my current location , [and] my readiness to proceed, [and whether I am in a situation conducive to private, uninterrupted communication.] By signing this consent, I understand and agree:**

1. Dr. Karla Benzl is located in a licensed by the State of California. Dr. Karla Benzl **may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact** Dr. Karla Benzl **. If I require emergency care, I may call 911 or** proceed to the nearest hospital emergency room help. [Or other relevant resource in patient's geographic area as discussed with Dr. Karla Benzl **. [If I am having suicidal thoughts or making or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273- TALK (8255) for free 24-hour hotline support.]**
2. I submit to the exclusive jurisdiction of the California State superior courts and agree that any claim, **lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provide by** Dr. Karla Benzl **will be brought solely and exclusively in California State superior courts. I also agree that the interpretation of this consent will be exclusively governed by and** construed in accordance with the laws of California.
3. Dr. Karla Benzl **believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect** anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.
4. If Dr. Karla Benzl believes at any time that another form of services (for example, a **traditional in-person consultation) would be appropriate, Dr.** Karla Benzl **may discontinue telemedicine services and schedule and in- person consultation with Dr.** Karla Benzl **or refer me to a healthcare provider in my area who can provide such** services.
5. **I have the right to withdraw consent to the use of telemedicine services at any time and receive in-person healthcare services with** Dr. Karla Benzl **.**
6. I received and explanation of how the electronic communication technology will be used for the **telemedicine services. I am comfortable with using electronic communications technology to communicate with** Dr. Karla Benzl **and understand there are limitations to communicate to the technology which may require and in-person consultation.**

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7. I agree to have the necessary computer, equipment and internet access for my telemedicine **communications. I also agree to arrange for a location with sufficient lighting and privacy that is free from distractions or intrusions during my telemedicine communications.**
8. The laws that protect privacy and the confidentiality of my medical information also apply to **telemedicine. The medical information that is transmitted electronically by Dr.** Dr. Karla Benzl **to me will be encrypted during transmission and will be stored only by Dr.** Dr. Karla Benzl **. I understand the dissemination of any personally –identifiable image** or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California State law.
9. **I understand my risks of a privacy violation increase substantially when I enter information on a** public access computer, use a computer that is on a shared network, allow a computer to "auto-remember" usernames and passwords, or use my work computer for personal communications. **I also understand this is my responsibility to encrypt medical information I transmit electronically to Dr.** Dr. Karla Benzl **and my failure to use technical safeguards, such and encryption, increases my risks of a privacy violations.**
10. **No part of the encounter will be recorded without my written consent.**
11. I have the right to access my medical information and obtain my copies of my medical records in accordance with California law.
12. I understand that the telemedicine services provided to me will be billed to my health insurance **company and that I will be billed for any patient responsibility as per my insurance.**

I read and understand the information provided in this Consent to Use of Telemedicine. I discussed any **question I had with** Dr. Karla Benzl **and all of my questions were answered to my satisfaction.**

_____ _____

**Date** **Patient's Signature**