CHILD - Behavioral Medicine Patient Registration

Please fill out the following information as completely as possible

Theapeutic Process
emotional evolution

Patient Name: _____ Date: _____ Age: _____

DOB: _____ Male_____ Female_____ Social Security # _____

Mailing Address: _____ City: _____ Zip: _____

Home Address: _____ Home Phone: _____

Marital Status: __Single __Married __Divorced __Widowed How Long? ____ __Years __Months

Previous Marriage(s)? __Yes __No **Give Dates:** _____ to _____ AND _____ to _____

Religious Preference *(optional)*: _____ Military Service: _____ Referred By: _____

Employer: _____ Occupation: _____ Years Employed: _____

Employer Address: _____ Work Phone: _____

Spouse Employer: _____ Work Phone: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Insurance I.D.# _____

Name of Policyholder: _____ SS# _____ DOB: _____

Employer: _____ Group # _____

Secondary Insurance Co. _____ Insurance I.D.# _____

Name of Policyholder: _____ SS# _____ DOB: _____

Employer: _____ Group # _____

David LaBonte, M. A. – Licensed Marriage Family Therapist | 4540 Campus Dr, Suite 122, Newport Beach, California 92660 | Phone: (949) 400-2032 | Email: davidlabonte@therapeuticprocess.com

Office Policies and Financial Contract with Consent for Treatment

Welcome to our office. We want your psychological needs to get the best and most efficient attention possible. A sound relationship between patient and therapist is based on a mutual understanding of these general office policies and the fees and financial arrangements involved. Sessions are by appointment only. After office hours, please leave a voicemail to re-schedule or cancel an appointment.

Treatment Philosophy

Outpatient psychotherapy consists of face-to-face contacts between a licensed professional and patient, and may include individual, group, family, short or long term therapy, crisis intervention or medication consultation. If your contract is with managed care, therapy will be brief and problem focused. You will be expected to participate in setting and achieving treatment goals.

A Case Manager oversees your number of sessions and will request information about your therapy. You will be asked to sign a release of confidential information for that purpose.

Attendance and Cancellation Notice

Regular attendance is necessary to receive the maximum benefit possible from treatment. Appointments are generally 45 minutes long and are reserved for you in our calendar. It is customary and reasonable to require that you give a **24-hour notice for a cancellation** of a scheduled appointment. You will be held liable for the full contracted rate of **$100.00** for broken appointments giving less than 24-hours notice. Managed care and insurance companies cannot be billed for these cancellation fees. A pattern of failure to keep appointments or failure to give 24-hour notice to cancel may be terms for the insurance or managed care company to disallow treatment. **(Please Initial: _____)**

Financial Contract, Deductibles, and Co-Payments

You are responsible for obtaining prior authorization from your insurance or managed care company prior to treatment. If this office accepts your insurance or we are contracted with your care company, you are responsible for the co-payment amount and the deductible as set by your benefit plan. Your contracted fee for the initial assessment is **$200.00.** Each follow up session is **$150.00.** If for any reason your insurance company does not pay these contracted rates, you will be held accountable for paying your balance. **(Please Initial: _____)**

Co-payment amounts are set by your benefit plan. These payments are due and payable at the beginning of each appointment. If you desire services not provided by your managed care company or benefits beyond your benefit contract, you will need to sign a separate written contract with this office. **(Please Initial: _____)**

Telephone Calls

If there should occur a time where essential concerns must be discussed on the telephone, the Provider charges at the same rate as the contracted rate above, based on the amount of time spent on the telephone. These charges will be your personal expense if they cannot be billed to your insurance company. **(Please Initial: _____)**

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Limits of Confidentiality

All information and records obtained during the course of treatment shall remain **confidential** and will not be released without a signed written consent. The legal exceptions to your confidentiality are as follows:

(1.) If a therapist believes that a patient intends to eminently commit serious bodily harm to another identifiable person or persons, it is the therapist's duty to warn the person or persons of intended harm as well as the authorities (Tarassoff vs. Regents of University of Cal., 1976).

(2.) If a therapist believes that a patient intends to eminently commit serious bodily harm to oneself, it is the therapist's duty to take necessary action to protect the individual, which may include notifying authorities (Johnson v. County of Los Angeles, 1983).

(3.) If a patient becomes involved in certain kinds of very important court cases, a judge may subpoena records and/or testimony. This is rare, but the therapist's ability to shield confidentiality in these cases may be compromised and varies from case-to-case.

(4.) If a therapist suspects that a child, elder, or dependent adult either is currently being abused, or has been abused in the past (where there is a risk of re-offense), and the authorities don't already know about it, it is the therapist's duty to inform the authorities (Welfare & Institution Codes, Penal Codes Section 11165, 11166 and others).

Releases of Information

Certain insurance companies (Medicare) and managed care companies ask us to get a release to the primary care physician to coordinate care. You may refuse this request or you can allow it. You will be asked if you wish to sign a release of confidentiality form.

If you are electing to use your insurance or managed care benefits, you will be required to sign a release of confidential information to your benefit plan so as to process claims for certification, case management, quality assurance, benefit administration and other purposes such as utilization. If you do not want such information to be shared with your benefit plan, you may pay privately without using your insurance company.

Consent for Treatment

I authorize and consent to treatment, which may include various psychological assessment techniques, psychological exams, diagnostic procedures, and psychotherapeutic services. I understand that while psychotherapy is intended to be helpful, no guarantees as to outcome can be made. The psychotherapeutic process can cause a person to experience unpleasant emotions, feelings and reactions such as anxiety, sadness, and anger. These responses are normal, if they should occur, and I agree to work through these responses with my therapist.

I accept and consent to the office policies, financial arrangements, as well as the terms of each of the foregoing paragraphs of this contract.

Patient Name: _____

_____ _____

Signature of Patient *(Parent/Guardian/Conservator)* Date

Therapist Signature: _____ **Date:** _____

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Consent and Authorization Affidavit for Child or Dependent Treatment

According to Part 1.5 (commencing with Section 6550) of Division 11 of the California Family Code, completion of questions below and the signing of the affidavit below are sufficient to authorize enrollment of a minor in psychological care.

Name of Minor *(print)*: _____ Minor's D.O.B.: _____

Present or Highest Grade of Education: _____ School Name: _____

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

City: _____ State: ___ ZIP: _____ City: _____ State: ___ ZIP: _____

Phone: _____ __*Home* __ *Cell* Phone: _____ __*Home* __ *Cell*

Legal Parent or Guardian *(print)*:_____

**Note: If you are not the parent or guardian, please discuss options with the office staff.*

Parent/Guardian Information:

Address: _____ City: _____ State: ___ ZIP: _____

Phone 1: _____ __*Home* __ *Cell* Phone 2: _____ __*Home* __ *Cell*

Parent/Guardian's **DOB**: _____ California Driver's License or ID#: _____

Affidavit

WARNING: *Do not sign this form if any of the statements above are false or you will be committing a CRIME.*

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____ _____

Signature of Patient *(Parent/Guardian/Conservator)* Date

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Policy Regarding Missed, Late, or Cancelled Appointments

When I miss a scheduled appointment and do not cancel the appointment at least 24 hours in advance, I understand that I will be charged for that broken appointment. It is my personal expense and the Insurance Company or Managed Care Company cannot be billed for my negligence.

I understand and agree that when I need to cancel an appointment, I will call the main office and either inform them directly or leave a message at **least twenty-four hours prior** to the scheduled appointment.

I agree to be billed at the contracted rate of $**100.00** for a missed appointment if I should fail to cancel twenty-four hours or more prior to the scheduled appointment.

_____ _____

Signature of Patient *(Parent/Guardian/Conservator)* Date

Therapist Signature: _____ **Date:** _____

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CHILD SYMPTOM RATING SCALE

CHILD'S NAME: _____

Please rate the highest severity of each symptom listed below during the ***past six months*** for your child by putting an "**X**" in the appropriate box to the right as follows: **0=None 1=Mild 2=Moderate 3=Severe 4=Profound**

	Symptom Description	0	1	2	3	4
1.	DEPRESSED/SAD MOOD/SELDOM SMILES					
2.	IRRITABLE/ANGRY MOOD					
3.	LOSS OF INTEREST OR PLEASURE IN THE USUAL THINGS					
4.	CRYING SPELLS					
5.	EATING PROBLEMS					
6.	WEIGHT GAIN OR LOSS - **Describe:**					
7.	PROBLEMS FALLING OR STAYING ASLEEP					
8.	SLEEPING TOO MUCH					
9.	FATIGUE, NO ENERGY					
10.	FEELINGS OF GUILT OR WORTHLESSNESS					
11.	CONCENTRATION PROBLEMS					
12.	LOW SELF ESTEEM					
13.	TALKS OF HATING SELF					
14.	HAS THOUGHTS OR TALKS ABOUT DEATH, OR WANTING TO DIE					
15.	HAS HURT SELF OR MADE THREATS TO HURT SELF					
16.	SUICIDE ATTEMPT OR THREAT - **Describe:**					
17.	WIDE DAILY MOOD SWINGS					
18.	INTENSE RAGES LASTING 30 MINUTES OR MORE					
19.	A FEW DAYS OF HIGH ENERGY					
20.	EXTRA TALKATIVE FOR DAYS					
21.	RACING THOUGHTS FOR DAYS					
22.	INTERRUPTS OTHERS					
23.	DIFFICULTY WAITING HIS/HER TURN					
24.	CAN'T SIT STILL, ACTS AS IF DRIVEN BY A MOTOR					
25.	INATTENTIVE, CAN'T LISTEN OR FOCUS IF IT'S NOT FUN					
26.	TROUBLE FINISHING TASKS; ATTENTION DRIFTS					
27.	ANXIETY, WORRY					
28.	EXCESS WORRY FOR 6 MONTHS					
29.	EXCESS WORRY ABOUT TWO OR MORE DIFFERENT ISSUES					
30.	MUSCLE TENSION					
31.	NIGHTMARES, FLASHBACKS, REPEATED THOUGHTS OF PAST UPSETTING TRAUMAS					
32.	INTENSE REACTION TO SOME REMINDERS OF TRAUMA					
33.	TRYING TO AVOID THINKING OF TRAUMA(S) OR OTHER REMINDERS OF TRAUMA					
34.	NERVOUS, ON GUARD					
35.	FEAR OF HUMILIATION CAUSES FEAR OF BEING WATCHED OR SEEN AND SOCIAL PROBLEMS					
36.	FEAR OF LEAVING HOME, CROWDS, OR LOUD NOISES					
37.	OTHER FEARS AND PHOBIAS					
38.	REPETITIVE ACTS LIKE COUNTING, CHECKING, WASHING					
39.	DISTRESSING THOUGHTS HE/SHE CAN'T GET RID OF					
40.	RESISTS GOING TO SCHOOL					

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Please continue rating the severity of symptoms within the ***past six months***:

0=None 1=Mild 2=Moderate 3=Severe 4=Profound

	Symptom Description	0	1	2	3	4
41.	LEARNING PROBLEMS					
42.	TICS, REPEATED MANNERISMS					
43.	BEDWETTING, SOILING					
44.	HEADACHES					
45.	STOMACH ACHES					
46.	BODY WEAKNESS					
47.	SEIZURES					
48.	IMMATURE					
49.	LITTLE INTEREST IN FRIENDS					
50.	VERY UPSET BY CHANGES					
51.	DELAYED SPEECH					
52.	HEARS VOICES					
53.	SEES THINGS NOT THERE					
54.	PROBLEMS AT HOME					
55.	PROBLEMS WITH SIBLINGS					
56.	OTHER SOCIAL PROBLEM					
57.	PROBLEM(S) AT SCHOOL					
58.	FREQUENT TANTRUMS LASTING 30 MINUTES OR LESS					
59.	CONFLICTS WITH ADULTS					
60.	ARGUES, OPPOSITIONAL					
61.	LIES					
62.	DESTROY'S OTHER'S PROPERTY					
63.	STEALS, LEGAL TROUBLE					
64.	LITTLE EMPATHY, CONCERN FOR OTHERS					
65.	CRUEL TO ANIMALS, PEOPLE					
66.	STARTS FIRES					
67.	HARMS OTHERS					
68.	MAKES THREATS OF HURTING OR WANTING TO KILL OTHERS					
69.	IMPROPER SEXUAL BEHAVIOR					
70.	DRUG USE PROBLEM-SELF - **Describe:**					
71.	DRUG USE PROBLEM-OTHER					

Has your child ***EVER*** been suicidal or engaged in self-harm behavior? ___**Yes** ___**No** If yes, please describe:

_____

_____

Has your child ***EVER*** been violent or dangerously aggressive towards others? ___**Yes** ___**No** If yes, please describe:

_____

_____

Please describe the symptoms that most concern you in more detail here: _____

_____

_____ _____ _____

Parent/Guardian Signature Date Therapist Signature

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

THIS AUTHORIZATION TO RELEASE, REQUEST OR DISCLOSE INFORMATION IS TO COMPLY WITH THE TERMS OF THE CONFIDENTIALITY OF MEDICAL INFORMATION ACT 1981, SECTION 56 ET SEQ., OF THE CALIFORNIA CIVIL CODE.

_____ **DOB:** _____ / _____ / _____
Patient Name MM DD YYYY

_____ _____ _____ _____
Address City State Zip

I Hereby Authorize the Release of Information:

___ TO AND FROM ___ TO ___ FROM: _____

Therapeutic Process – emotional evolution
4540 Campus Dr, Suite 122
Newport Beach, CA. 92660
949.400.2032

And my (the patient's) **HEALTH INSURANCE**: Company Name: _____

Limits on information disclosure: ___ None
___ Limit To: _____
_____

I understand that I can receive a copy of the authorization upon my request.

This authorization may be removed in writing at any time by the undersigned, and if not earlier revoked, shall terminate on: _____ .
Date or Terms

_____ _____
Signature of Patient *(Parent/Guardian/Conservator)* Date

Therapist Signature: _____ **Date:** _____

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_____ **DOB:** _____ / _____ / _____
Patient Name MM DD YYYY

_____ _____ _____ _____
Address City State Zip

For coordination of care, I hereby authorize the release of information:

___ TO AND FROM ___ TO ___ FROM: _____

Therapeutic Process – emotional evolution
4540 Campus Dr, Suite 122
Newport Beach, CA. 92660
949.400.2032

And my (the patient's) **physician**: Doctor's Name: _____

Address: _____ City: _____ State: ___ ZIP: _____

Phone: _____ Fax: _____

Limits on information disclosure: ___ None
___ Limit To: _____
_____

*** OR ***

___ *At this time I do NOT wish to have any information released to my physician.*

I understand that I can receive a copy of the authorization upon my request.
This authorization may be removed in writing at any time by the undersigned, and if not earlier revoked, shall terminate on: _____ .
Date or Terms

_____ _____
Signature of Patient *(Parent/Guardian/Conservator)* Date

Therapist Signature: _____ **Date:** _____

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INITIAL ASSESSMENT QUESTIONNAIRE

Briefly describe why you are seeking treatment today. Please include the Psychological and Social factors and provide a brief history.

_____
_____
_____
_____
_____
_____

What single ***specific event*** made you seek consultation ***today*** as opposed to an earlier time?

_____
_____
_____
_____
_____
_____

How long has the chief complaint been present? _____
_____

What are your medical concerns? _____
_____

Any Special Status Issues? __Court Mandated __Criminal Family Court __Work Related __Disability
Other: _____

What are the expectations for treatment outcome? _____
_____

Household Members

	Names	Age	Relationship
1:	_____	_____	_____
2:	_____	_____	_____
3:	_____	_____	_____
4:	_____	_____	_____
5:	_____	_____	_____
6:	_____	_____	_____
7:	_____	_____	_____
8:	_____	_____	_____

CLIENT NAME: _____

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MEDICAL AND BEHAVIORAL HEALTH HISTORY

Behavioral Health History:

Has patient been in counseling before? ___**Yes** ___**No**

When? Where? How Long? With Whom? Successful? Why Stopped? _____

_____

_____

_____

Do you want the Therapist to get records? ___**Yes** ___**No**

For what was the patient being treated? Diagnosis? _____

_____

_____

Has patient been hospitalized for a mental health illness? ___**Yes** ___**No**

When? Where? How Long? _____

_____

Is there a history of suicidal thoughts or attempts? ___**Yes** ___**No**

Please Explain: _____

_____

Any history of self-injury? ___**Yes** ___**No**

Please Explain: _____

_____

Is there a family history of suicide or homicide? ___**Yes** ___**No**

Please Explain: _____

_____

Have any close relatives used medication for mental health? ___**Yes** ___**No**

Please mark below any family members who have suffered with mental illness or alcoholism.

____ *Biological Father*
____ *Biological Mother*
____ *Brother(s)*
____ *Sister(s)*
____ *Paternal Grandparents*
____ *Maternal Grandparents*
____ *Paternal Aunts & Uncles*
____ *Maternal Aunts & Uncles*
____ *Paternal Cousins*
____ *Maternal Cousins*

Has patient been hospitalized for alcohol or drug abuse/dependency? ___**Yes** ___**No**

Please Explain: _____

Has patient used: ___**AA** ___**NA** ___Other community resources (please list below)

_____ _____ _____

CLIENT NAME: _____

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Behavioral Health History *(continued)*:

Does patient use alcohol? ___**Yes** ___**No** How often?_____ How Long? ____ __Years __Months

Does patient smoke? ___**Yes** ___**No** How often?_____ How Long? ____ __Years __Months

Does patient use caffeine? ___**Yes** ___**No** How often?_____ How Long? ____ __Years __Months

Explain Caffeine Use: _____

Has patient ever had medication prescribed for mental health reasons? ___**Yes** ___**No**

Please describe any allergies or bad side effects from previously prescribed medications: _____

_____

_____

_____

Does patient have allergies? ___**Yes** ___**No**

Please Describe Allergies: _____

_____

PLEASE LIST ALL CURRENT MEDICATIONS:

	Medications	**Amount**	**How Often**	**Reason**
1:	_____	_____	_____	_____
2:	_____	_____	_____	_____
3:	_____	_____	_____	_____
4:	_____	_____	_____	_____
5:	_____	_____	_____	_____
6:	_____	_____	_____	_____
7:	_____	_____	_____	_____
8:	_____	_____	_____	_____

Prescribing Physician's Name	**Address**	**Phone #**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you want to sign a Release Of Information to the M.D.? ___**Yes** ___**No**

CLIENT NAME: _____

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Medical History:

Are there any current medical problems? ___**Yes** ___**No**
If yes, please explain. What effect does your medical condition have on your mental health?

_____

_____

Please indicate if you have had or are experiencing any of the following conditions:

__ Cardiovascular disease
__ Heart disease
__ Chest pain or angina
__ Swelling of hands, feet or ankles
__ Hypertension
__Stroke(s)
__ Gastrointestinal disorder
__ Frequent diarrhea
__ Peptic ulcer
__ Endocrine Disorder
__ Hormonal change
__ Hormone Replacement
__ Diabetes
__ Colder than before
__ Frequent infections or boils
__ Skin is becoming dryer
__ Thyroid dysfunction
__ Genitourinary problems
__ Renal (kidney) disease
__ Liver disease
__ Hepatitis
__ Jaundice
__ Neurological disorder
__ Seizures
__ Rendered unconscious
__ Concussion or head injury
__ Blood disorders
__ Malignancy
__ Eye disorders
__ Glaucoma
__ Respiratory problems
__ Asthma or wheezing
Other: _____

Please give details below to the above medical conditions to which you indicated: _____

_____

_____

_____

Has there been a recent medical check-up, or lab work done? ___**Yes** ___**No** If yes, When? _____

Do you want release of information signed for your medical history? ___**Yes** ___**No**

Please mark in the appropriate box for anyone in the family history who have had any of the following, whether formally diagnosed or not: **Key**: **B**=brother **S**=sister **F**-father **GM**-grandmother **GF**-grandfather **U**-uncle **A**-aunt **C**-cousin.

Family Behavior History				Father's Side of Family						Mother's Side of Family					
Condition	**Self**	**B**	**S**	**F**	**GM**	**GF**	**U**	**A**	**C**	**M**	**GM**	**GF**	**U**	**A**	**C**
Attention Deficit or Inattention															
Hyperactivity															
Oppositional Defiance															
Bipolar															
Depression															
Anxiety															
Social Avoidance															
Other: _____															

CLIENT NAME: _____

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Social History

Is patient married or in a current relationship? Is the relationship supportive or problematic? Please be specific:

_____
_____
_____
_____

Is patient experiencing any current problems with family members? ___**Yes** ___**No** Please Explain:

_____
_____
_____
_____

Patient's birth order among siblings: _____

How was the patient raised? ____ Natural Parents ____ Foster Parents ____ Adopted ____ Intact Family
____ Single Parent Home ____ Parents Separated ____ Divorced

Please describe the parental style of your parents. Include events which may be relevant.

_____
_____
_____
_____

Please indicate the major stressors in your life from the following:

___Health ___Finances ___Housing ___Work ___Culture ___Religion ___Ethnicity
___Education ___ Age Related Concerns ___Relationships ___Other *(please explain below)*:

_____
_____
_____
_____
_____

Notes: _____
_____
_____
_____
_____
_____
_____

CHILD'S NAME: _____

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CHILD AND ADOLESCENT ASSESMENT:
PRENATAL, PARINATAL AND DEVELOPMENTAL HISTORY

Fetal Health Prior to Birth:

Was there any exposure to illicit or prescribed drugs? ___**Yes** ___**No**
If yes, please explain the circumstances including type of drugs:
Alcohol: _____
Street Drugs: _____
Prescription Meds: _____
Tobacco: _____
Caffeine: _____
Other: _____

Any unusual problems during pregnancy? ___**Yes** ___**No** If yes, please explain: _____
_____
_____

Any complications during delivery? ___**Yes** ___**No** If yes, please explain: _____
_____
_____

Do you have any concerns about your child's development? ___**Yes** ___**No** If yes, Indicate all that apply:
__*Feeding* __*Sleeping* __*Talking* __*Walking* __*Toilet Training* __*First Word* __*Transition to School* __ *Other*
If Other, please explain: _____
_____

Does your child suffer from any common or childhood illnesses? ___**Yes** ___**No** If yes, please explain:
_____
_____

Has your child had any surgeries or hospitalizations? ___**Yes** ___**No** If yes, please explain (*Including Dates)*:
_____
_____

Have there been any disabilities or functional impairments due to illness? ___**Yes** ___**No**
If yes, please explain: _____
_____

Does your child have school learning problems? ___**Yes** ___**No** If yes, give details:
(special education or evaluated for specific learning disabilities): _____
_____
_____

Describe history of the school learning problem by grade level: _____
_____
_____

CHILD'S NAME: _____

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Does your child have behavioral problems? ___**Yes** ___**No** If yes, please explain:

_____

_____

Does your child have discipline problems? ___**Yes** ___**No** If yes, please explain:

_____

_____

Do you have any concerns about your child's emotions? ___**Yes** ___**No** If yes, Indicate all that apply:
__*Fears* __*Anger* __*Depression* __*Shy* __*Unmotivated* __*Hyperactive* __*Other*
If Other, please explain: _____

_____

Please give a brief history of the above behavioral or emotional problems, including home and school functioning. Include how it has affected elementary, junior high and high school: _____

_____

_____

_____

_____

Does your child have any diagnosed medical problems or allergies? ___**Yes** ___**No** If yes, please explain:

_____

_____

Has your child ever been physically, sexually or emotionally abused? ___**Yes** ___**No** If yes, please explain:

_____

_____

Does your child have problems with siblings? ___**Yes** ___**No** If yes, please explain: _____

_____

_____

Does your child have any legal difficulties? ___**Yes** ___**No** If yes, please explain: _____

_____

_____

Briefly describe your child's interests and activities: _____

_____

_____

What do you like best about your child? _____

_____

_____

CHILD'S NAME: _____

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NOTICE OF PRIVACY PRACTICES

Effective Date: **Immediately**

This Information is made available to all patients

THIS NOTICE DESCRIBES HOW BEHAVIORAL HEALTH/MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE APPLIES TO ALL THE RECORDS OF YOUR CARE GENERATED BY THE PRACTICE, WHETHER MADE BY THE PRACTICE OR AN ASSOCIATED FACILITY.

This notice describes our Practice's policies, which extend to:

- Any health care professional authorized to enter information into your chart. (Including all behavioral health care professionals, RNs, etc.);
- All areas of the Practice (front desk, administration, billing and collection, etc.
- All employees, staff and other personnel that work for or with our Practice.
- Our business associates, (including billing services).
- Behavioral health hospitals, and so on.

The Practice provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR THOUGHTS ABOUT YOUR PROTECTED HEALTH INFORMATION

We understand that your behavioral health/medical information is personal to you, and we are committed to protecting the information about you. As your behavioral health professional, we create paper and electronic professional records about your behavioral/physical health, our care for you, and the services and/or items we provide to you. We need this record to provide for your care and to comply with certain legal requirements.

We are required by law to make sure that the protected health information about you is kept private, provide you with a Notice of our Privacy Practices and your legal rights with respect to protected health information about you, and follow the conditions of the Notice that is currently in effect.

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HOW WE MAY USE AND DISCLOSE BEHAVIORAL HEALTH/MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose protected health information that we have and share with others. Each category of uses or disclosure provides a general explanation and some examples of uses. Not every use or disclosure in a category is either listed or actually in place.
The explanation is provided for your general information only.

1) Behavioral Health/Medical Treatment: We use previously given behavioral health/medical information about you to provide you with current or prospective behavioral health treatment or services. Different employees within the Practice also may share information about you including your record(s), prescriptions, and requests of lab work history, treatment, and diagnosis. We may also discuss your behavioral health information with you to recommend possible treatment options. We also may disclose information about you to people outside the Practice who may be involved in your behavioral/medical care after you leave the Practice; this may include your family members, friends, or other personal representatives, **but only if** authorized by you or by a legal mandate (a guardian or other person who has been named to handle your medical decisions, should you become incompetent).

2) Payment: We may use and disclose behavioral health/medical information about you for services and procedures so they may be billed and collected from you, an insurance company, or any other third party. For example, we may need to give your health care information, about treatment you received at the Practice, to obtain payment or reimbursement for the care. We may also tell your health plan about treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

3) Health Care Operations: Within our practice, we may use and disclose behavioral health/medical Information about you so that we can run our Practice more efficiently and make sure that all of our patients receive quality care. These uses may include reviewing our treatment and services to evaluate the performance of our staff, deciding what additional services to offer and where, deciding what services are not needed, and whether certain new treatments are effective. For both of the following, we will remove information that identifies you from the set of information so others may use it to study health care and health care delivery without learning who the specific patients are. In this non-identifying way, we may also disclose information to doctors, nurses, technicians, mental health/medical students, and other personnel for review and learning purposes.

4) Disclosure: We may also use or disclose information about you for internal or external utilization review and/or quality assurance to auditors to verify our records, to billing companies to aid us in this process and the like. We shall endeavor, at all times when business associates are used, to advise them of their continued obligation to maintain the privacy of your behavioral health/medical records. We expect then to keep your information in strict confidence.

5) Appointment and Patient Reminders: We may ask that you sign in writing at the Receptionist's Desk or waiting area, a "Sign In" log on the day of your appointment with the Practice. We may use and disclose behavioral health/medical information to contact you as a reminder that you have an appointment for medical care with the practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, e-mail, or otherwise and may involve the leaving of an e-mail, a message on an answering machine, or otherwise which could (potentially) be received or intercepted by others. You have the right, detailed on the next page, to let us know if you prefer some specific form of this communication.

6) Emergency Situations: In addition, we may disclose behavioral health/medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status and location.

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Other Uses of Behavioral Health/Medical Information

Other uses and disclosures of behavioral Health/Medical information not covered by this notice or the laws that apply to us will be made only with your written permission, unless those uses can be very reasonably inferred from the intended uses above. If you have provides us with your permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke our permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Patient Rights

THIS SECTION DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THIS PRACTICE REGARDING THE USE AND DISCLOSURE OF YOUR BEHAVIORAL HEALTH/MEDICAL INFORMATION.

You have the following rights regarding Behavioral Health/Medical information we maintain about you:

1) Right to Inspect and Copy: You have the right to inspect and copy behavioral health/medical information that may be used to make decisions about your care. This includes your own billing records, **but does not include psychotherapy notes.** Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

   To inspect and copy your behavioral health/medical record, you must submit your request in writing to our Compliance Officer. Ask the front desk person for the name of the Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies (tapes, disks, etc.) associated with your request.

   We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to behavioral/medical information, you may request that our Compliance Committee review the denial. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome and recommendations from that review.

2) Right to Amend: If you feel that the behavioral health/medical information we have about you (**not including psychotherapy notes**), in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the Practice maintains your record.

   To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

   We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

   - *Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;*
   - *Is not part of the behavioral health/medical information kept by or for the Practice;*
   - *Is not part of the information which you would be permitted to inspect and copy; or*
   - *Is inaccurate and incomplete.*

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3) Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of the disclosures we may have made of behavioral health/medical information about you to others. To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) years back and may not include dates before Aril 14, 2003 (or the actual implementation date of the HIPAA Privacy Regulations). Your request should indicate in what form you want the list (for example, on paper, electronically). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

4) Right to Request Restrictions: In general, your information will not be released to anyone except as outlined in this document. However, you have the right to request a restriction or limitation on the behavioral/medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the behavioral health/medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or friend). For example, you could ask that we not use or disclose information about a particular treatment you received.

   We may not be able to comply with your request, if the information is exempted from the consent requirement or we are otherwise required to disclose the information by law. To request restrictions, you must make your request in writing. In your request, you indicate:
   - *What information you want to limit;*
   - *Whether you want to limit our use, disclosure or both; and*
   - *To whom you want the limits to apply, (e.g., disclosure to your parents, spouse, etc.)*

5) Right to Request Confidential Communications: You have the right to request that we communicate with you about behavioral health/medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail or e-mail, or the like. To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish us to contact you.

6) Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

7) Research: Under certain circumstances, we may use and disclose medical information about you for research purposes regarding medications, if you are taking any, efficiency of treatment protocols and the like. All research projects are subject to an approval process, which evaluates a proposed research project and its use of behavioral health/medical information. Before we use or disclose information for research, the project will have been approved through the research approval process. We will obtain a written Authorization from you before using or disclosing your individually identifiable health information. Otherwise we will make the information non-identifiable to a specific patient. If the information has been sufficiently de-identified, an authorization for the use or disclosure in not required.

8) Required by Law: We will disclose behavioral health/medical information about you when required to do so by federal, state, or local law. Psychotherapy notes are especially guarded, and are considered confidential in most cases.

9) To Avert a Serious Threat to Health or Safety: We may use and disclose behavioral health/medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

10) Workers' Compensation: We may release behavioral health/medical information about you for workers' compensation or similar programs, if you are claiming a behavioral health injury and we are ordered to do so by legal authority. Workers' compensation programs provide benefits for work-related injuries or illness.

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11) Public health Risks: Law or public policy may require us to disclose behavioral health/medical information about you for public health activities. These activities generally include the need to report births and deaths; or to notify the appropriate government authority if we believe a child, elder, or dependent adult has been the victim of abuse or neglect. We will only make this disclosure if you agree or when required or authorized by law.

12) Investigation and Government Activities: We may disclose behavioral health/medical information to a local, state or federal agency for activities authorized by laws. These oversight activities include, for example, audits, investigation, inspections, and licensure. These activities are necessary for the payor, the government and other regulatory agencies to monitor the health care system, government programs, & compliance with civil rights laws.

13) Lawsuits and Disputes: If you are involved in a lawsuit or legal dispute, we may disclose medical information about you in response to a judge's order. This is particularly true if you make your behavioral health an issue in the case. Otherwise, judges do not order the violation of the confidentiality of behavioral health records lightly. They only do so if they consider the information critical for a highly important matter. We may also use your information to defend ourselves or any member of our Practice in any actual or threatened legal action.

14) Law Enforcement: We may release behavioral health/medical information if asked to do so by a law enforcement official under the following circumstances:
    - *To identify or locate a suspect, fugitive, material witness, or missing person;*
    - *About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;*
    - *About a death we believe may be the result of criminal conduct;*
    - *About criminal conduct at the Practice; and*
    - *In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.*

15) Coroners, Medical Examiners and Funeral Directors: We may release behavioral Health/Medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release behavioral health/medical information about patients of the practice to funeral directors as necessary to carry out their duties.

16) Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release behavioral/medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

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CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for behavioral health/medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the Practice. The notice will contain on the first page, in the top right-hand corner, the date of last revision and effective date. In addition, each time you visit the Practice for treatment or health care services you may request a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact or office manager, who will direct you on how to file an office complaint. All complaints must be submitted in writing, and all complaints shall be investigated, without repercussion to you.

You will not be penalized for filing a complaint.

Acceptance of HIPAA Privacy Notice

I certify that I have received a copy of the HIPAA authorization.

Patient Name: _____
Please Print

_____ _____
Signature of Patient *(Parent/Guardian/Conservator)* Date

Therapist Signature: _____ **Date:** _____

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