SAINT SOPHIE'S PSYCHIATRIC CENTER	Patient Name: Date of Birth:	
Consent & Agreement to Pay and Authorization Assignment		Rev 05/2016

I, knowing that I (or ______________________________________) have a **condition requiring diagnosis and treatment, do hereby voluntarily consent** to such diagnostic procedures and care as provided by my Saint Sophie's clinician's instructions. I consent and agree generally to assessments, psychological testing, individual, group and family therapy services. My right to information about or to refuse any test or procedure is not altered by this agreement.

Treatment is provided by medical doctors and licensed clinicians. Under the direction and supervision of the psychiatrist or other licensed clinicians of my team, students, residents or interns may perform or observe some of the health care services I receive.

I consent to a photograph to be taken for accurate identification. I understand that this photograph becomes a permanent part of the patient's medical records, and is treated like other documents within the medical record.

I have been informed and am aware that security cameras are used on the premises.
I further acknowledge that no guarantees have been made to me as to the results of treatment or examination at Saint Sophie's.

In consideration of the services provided by any and all clinicians for care and treatment, including consultations rendered to ____ for a period of such care and treatment commencing on or about the _____ day of ___________________, 201__, **I hereby assign and authorize payment directly to Saint Sophie's, LLC and said clinicians of any and all Medicare/insurance benefits otherwise payable to me.**

I hereby agree that Saint Sophie's and the clinicians may receipt me for any such payment and that such receipt shall be a conclusive acknowledgment by me that I have received insurance benefits from the insurance company(ies) in the sum specified in such receipt, and agree that such payment shall discharge the insurance company(ies) of any and all obligations under the policy(ies) to the extent of such payment and for that purpose. **I expressly authorize Saint Sophie's and the clinician(s) to furnish the insurance company(ies) with any information desired concerning said care and treatment.** I understand that **I am financially responsible to Saint Sophie's and the clinician(s) for charges not covered by this assignment** and further **agree to guarantee prompt payment in full of any balance**. The original copy of this agreement of this authorization shall be kept permanently in Medical Records, therefore a photocopy shall be considered as valid as the original.

____
Signature of Patient or if Patient is a minor or is physically incompetent, signature/relationship of closest relative or Legal guardian)

Date: ________________________________

____
Signature of Policyholder (if Patient is Policyholder)

Date: ________________________________

Staff Witness______________________________

Date: ________________________________

SAINT SOPHIE'S PSYCHIATRIC CENTER	Patient Name: Date of Birth:	
Financial Policy		Rev 08/2019 Page 1 of 2

At Saint Sophie's, we are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an important element of your care and treatment. This Financial Policy is to assist you. If you have questions, please feel free to discuss them with our Patient Financial Services Staff.

Unless either you or your health coverage carrier has made other arrangements in advance, full payment is due at the time of service. For insured patients, this includes any co-payments, co-insurance amounts and/or deductibles.

YOUR INSURANCE: If you have insurance, we will file your claim with your insurance company, as a courtesy to you. We will extend payment terms up to 60 days in order to provide you with enough time to resolve your insurance claims. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. For patients covered by more than one policy, we also file claims to the "secondary" insurance.
As insurance carriers tend to change frequently, it is the policyholder's responsibility to determine whether or not we are contracted providers before being seen.
To allow for filing of your insurance benefits, you must bring your insurance card upon admission as well as at any time your insurance coverage changes.

Please be aware that few insurance companies attempt to cover all medical costs. You are responsible for payment regardless of any insurance company's determination of usual and customary rates that may bear no relationship to the current standard and cost of care in this area. If there are any disputes with your insurance carrier regarding your policy guidelines and insurance payments, it is important that you be involved to ensure that you receive the full benefit due you.
Insurance policies vary widely in how they pay for mental health services. Often pre-authorizations are required for a specific number of visits. In some cases, an initial referral from a primary care doctor is needed. Depending on your policy, your involvement may be critical, for some steps in the process, such as obtaining an initial referral.

___________**I understand that any appointment that is not cancelled 24 hours prior to the appointment time will have an $80 fee that is not covered by insurance.**

__________I Authorize Saint Sophie's to contact my primary care physician / Managed Care Network on my behalf to request a referral that may result in coverage at the "in Network" benefit level.

___________**Authorization for release of information to Insurance Companies:** By initialing and signing below, you are authorizing Saint Sophie's to release medical information to your insurance company, including governmental payers such as Medicare, Medical Assistance and Worker's Compensation as required or permitted by law. This includes but may not be limited to confidential medical information which may include **drug/alcohol abuse, HIV status, or psychiatric treatment** as necessary for payment of claims. This may include verbal, written or faxed information.

I understand that Chemical Dependency client's/patient's records are protected by the Federal Law (42CFR Part 2) and cannot be disclosed without this written consent unless otherwise provided in the federal regulations. My signature also means that I have read this form and / or have had it read to me and explained in a language that I can understand.

Your doctor, practitioner, or therapist can explain the reasons for the different kind of charges used, such as evaluations, individual therapy, or family therapy.

METHODS OF PAYMENT: We accept cash, check, VISA, and MasterCard. We do not accept post-dated checks, nor will we hold checks for any length of time. Payment arrangements may be made in advance of your appointment as necessary.

INFORMATION CHANGES: Be sure to advise us of any address or phone number changes. We cannot be responsible for delinquent accounts due to lack of receipt of statements or other correspondence if we do not have a current or correct address or phone number on file.

COLLECTION PROCEDURES: Patient Account Representatives are available to help with payment arrangements from 8:00am to 4:30pm Monday thru Friday. We do have a Hardship Program available for those patients who qualify. Once made in writing, agreements are binding. Our collection procedure does not begin until 30 days after your insurance has paid their portions, 60 days if they have not. Failure to respond to communications from our office may result in termination of treatment and/or involvement of an outside collection agency. You will be responsible for any fees or interest charged in association with collection of your account.

ASSIGNMENT OF BENEFITS: If you have health care insurance or are entitled to benefits under any private or government health plan or policy, you agree that Saint Sophie's may bill these priors and they may make their payments directly to Saint Sophie's. Your signature on this form is your authorized signature for the filing of a claim and request for direct payment of benefits by any payer to Saint Sophie's.

I have read and understand this financial policy of Saint Sophie's and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the organization.

______________________________ ______________________________

Patient's Name | Social Security Number

______________________________ ______________________________

Witness | Signature of Patient or Responsible Party

______________________________ ______________________________

Date | Account Number

Acknowledgement of Receipt Notice of Privacy Practices	Patient Name: Date of Birth:	Rev 05/2016

It is our responsibility and intent to protect the confidentiality of our patients to the fullest extent permitted by law and according to the wishes of our patients.

The Health Insurance Portability and Accountability Act of 1996, known as HIPAA, includes important practices for healthcare organizations regarding the privacy and security of patient information.

Your signature below acknowledges you have received the Notice of Privacy Practices. This notice describes how a patient's protected health information (PHI) may be used or disclosed to carry out treatment, payment, or healthcare operations and for other purposes that are permitted or required by law. The notice also details patient rights and our duties regarding their PHI.

Thank you.

Saint Sophie's

______________________________________ ____________

Patient/Guardian Signature **Date**

SAINT SOPHIE'S PSYCHIATRIC CENTER	Patient Name: Date of Birth:	
Medication History		Rev 08/2019

Medication History:

What medications are you currently taking? (include ALL medications, over-the-counter medications, herbal remedies)

- ____
- ____
- ____
- ____
- ____
- ____
- ____

What medications have you taken in the past? (Include ALL medications, over-the-counter medications, herbal remedies)

- ____
- ____
- ____
- ____
- ____

Allergies:

Substance/Medication: Reaction:

- ____
- ____
- ____
- ____
- ____
- ____

Review of Systems	Patient Name:	
	Date of Birth:	Rev 08/2019

Does the patient experience any of the following? Please check all that apply:

General: ☐ Appetite Loss ☐ Fatigue ☐ Fever ☐ Obesity ☐ Weight Change

Skin: ☐ Bruising ☐ Rashes ☐ Excessive Sweating

HEENT: ☐ Headache ☐ Visual Problems ☐ Hearing Problems

Neck: ☐ Neck Pain ☐ Swollen Glands

Resp: ☐ Asthma ☐ Bronchitis ☐ Coughing ☐ Wheezing ☐ Difficulty Breathing

CV: ☐ Blood Pressure Problems ☐ Chest Pain ☐ Swelling of Legs ☐ Shortness of Breath
☐ History of family member dying suddenly

GI: ☐ Abdominal Pain ☐ Diarrhea ☐ Constipation ☐ Trouble Swallowing

GU: ☐ Bedwetting ☐ Sexual Problems ☐ Troubles Urinating

MS: ☐ Back Pain ☐ Joint Pain ☐ Weak Muscles

Neuro: ☐ Seizures ☐ Decreased Memory ☐ Loss of Consciousness

Psych: ☐ Anxiety ☐ Depression ☐ Circumscribed Interest ☐ Attention Problems
☐ Hallucinations ☐ Hyper Focus ☐ Panic Attacks ☐ Suicidal Thoughts
☐ Suicidal Planning

Endo: ☐ Cold Intolerance ☐ Diabetes ☐ Excessive Thirst ☐ Excessive Urination
☐ Thyroid Problems

Hem: ☐ Anemia ☐ Easy Bleeding ☐ Enlarged Glands

For Female Patients:

Breast: ☐ Mass ☐ Pain

Menstrual: ☐ Bloating ☐ Cramping ☐ Irregularity ☐ Pelvic Pain

Please fill out this questionnaire and return it to Saint Sophie's in the envelope provided before your child's appointment. It asks about general background information that may be relevant to your child's evaluation.

Date: __________

Born Sex:_____________ Identifies as:_________________________ Ethnicity: _________________

Grade: ________________ School: ______________________________________

Person Completing form & Relationship: ____

CHILD DEVELOPMENT

Note any problems in the space provided

Pregnancy ____

(e.g., medications taken, drugs/alcohol, illness, complications?)

Labor ____

(e.g., spontaneous, induced, duration?)

Delivery ____

(e.g., C-section, forceps, distress, APGARS?)

Birth weight: __________________ Went home with mother? ______________________________

Neonatal/Infancy ____

(e.g., jaundice, convulsions, colic, problems breathing, infections?)

Estimate the age at which your child could:

_______ Walk _______ Catch a ball

_______ Speak words _______ Tie shoelaces

_______ Speak simple sentences _______ Toilet trained: Day ___________ Night _______

As a baby, my child was (check all that apply):

☐ calm ☐ active ☐ difficult ☐ good sleeper ☐ easily upset ☐ affectionate

☐ quiet ☐ loud ☐ difficult to care for ☐ ate well ☐ stubborn ☐ predictable

If any of the following occurred as a young child, note the age:

________ Nonsense speech or made-up words ________ Poor pronunciation

________ Repeating other's speech ________ Clumsiness

________ Ignored people or other children ________ Withdrawn

If any of the following occurred as a young child, note the age:

________ Odd movements ________ Head-banging

________ Nightmares, night terrors ________ Bedwetting (after age 6)

________ Excessive anxiety about going to school

________ Excessive anxiety about separation from parents

________ Repeating behaviors excessively, e.g. twirling in circles, lining up toys

If there was testing or therapy for any of the following, note the age and where:

________ Speech ____

________ Vision ____

________ Hearing ____

________ Learning ____

________ Neurological ____

________ Is child receiving special services at school? ________ YES ________ NO

MEDICAL HISTORY

Note the age and describe any of the following:

________ Seizures ____

________ Surgeries ____

________ Hospitalizations ____

________ Serious Illnesses ____

Current Medical Problems: ____

____

____

____

Regular Care Provider: ____

Previous Psychiatric/Mental Health/Counseling Services:

____

____

____

____

____

____

____

____

SOCIAL HISTORY

Child lives with:
- ☐ Biological parents
- ☐ Adoptive parents
- ☐ Parent & stepparent
- ☐ Foster parents
- ☐ One parent alone
- ☐ Institution
- ☐ Relatives
- ☐ Other

Status of Parents: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced ☐ Widowed

Composition: Please list the names, ages, and relation of everyone who lives at home:

Name	Age	Relation

Who has custody at this time? ____

Was the child exposed to any type of abuse (sexual, physical, emotional, verbal etc) If so, describe type, by whom, duration:

____

____

____

____

FAMILY HISTORY: Has anyone in the immediate or extended family needed help for emotional, behavioral, psychiatric or neurological problems or other serious medical problems? If so, please list and describe the problems as best as you can and the family member's relation to the child.

____

____

____

____

Have any of the following events occurred in your family? Note when and describe:

Death in family/other losses: ______________________________

____

Change in family's financial status: ______________________________

____

Job changes: ______________________________

____

Divorce or separation: ______________________________

____

Moves: ______________________________

____

Please describe parents' marital relationship:

☐ Smooth ☐ Occasional difficulties ☐ Frequent difficulties ☐ Failure

Please describe agreement between parents on how to deal with child's problems:

☐ Usually agree ☐ Sometimes agree ☐ Never agree

Are there any significant events that occurred in either parent's upbringing that would be important for us to know in working with the family? (e.g., chemical dependency, chronic family fighting, abuse)

___

___

Has the child drank alcohol? If yes, please describe: ___

___

___

Has the child used street drugs? If yes, please describe: ___

___

___

Has the child smoked cigarettes or used tobacco products? If yes, please describe: ___

___

___

Any legal issues in the past or present? If so, please describe:

___

___

___

Any employment in the past or present? If so, please describe:

___

___

___

Mood Disorder Questionnaire

Please answer the questions to the best of your ability. Has there ever been a period of time when you were not your usual self and..

You felt so good or so hyper that other people thought you were not your normal self or you got into trouble	Y	N
You were so irritable that you shouted at people or started fights or arguments	Y	N
You felt much more self-confident than usual	Y	N
Thoughts raced through your head or you couldn't slow your mind down	Y	N
You were so easily distracted by things around you that you had trouble concentrating or staying on track	Y	N
You had more energy than usual	Y	N
You were much more active or did many more things than usual	Y	N
You were much more social or outgoing than usual, for example you called friends in the middle of the night	Y	N
You were much more interested in sex than usual	Y	N
You did things that were unusual for you or that other people might have thought were excessive, foolish, or risky	Y	N
Spending money got you or your family in trouble	Y	N

PC-PTSD-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. If you have ever experienced this type of event, please answer the following:

Had nightmares about the event(s) or thought about the event(s) when you did not want to	Y	N
Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)	Y	N
Been constantly on guard, watchful, or easily startled	Y	N
Felt numb or detached form people, activities, or your surroundings	Y	N
Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused	Y	N

Please describe what happened that was especially or unusually frightening, horrible or traumatic?____

Please list any other problems you feel are important: ____

____

____

List questions you would like answered at this appointment if possible:

- ____
- ____
- ____

SAINT SOPHIE'S
PSYCHIATRIC CENTER

REGISTRATION

Patient Name:____ Birth date:____________________
Last First MI

Address:____ Sex: M ☐ F ☐

____ Marital status: S ☐ M ☐ D ☐ W ☐

Recent Name Change:____ Social Security #:____________
(Maiden Name or Previous Married Name)

Phone # (H):___________________________________ Phone # (W):______________________________

Employer Name: _______________________________ Employer Address:_________________________

Primary Care Physician:__________________________ Referring Physician:_______________________

Names of Other Family Members Living at Home:___________________ ________________ __________

Email Address: ____

Emergency Information (Nearest friend / relative to contact in an emergency, not living with you.)

Name:____Relationship:___________________________

Address:_________________________________Phone # (H):______________________________

____ Phone # (W):______________________________

Responsible Party: Self ☐ Spouse ☐ Parent ☐ Other ☐ (___________) Birth date:______________

Name:____ SS#__________________________________

Address: (if different from above)

____ Phone # (H):______________________________

____ Phone # (W)______________________________

Employer Name and Address:____

Work Related Injury? (check one) Y ☐ N ☐
Auto / Other Accident Injury? Y ☐ N ☐

Insurance Information –

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Name of Insurance ___________________________	Name of Insurance ___________________________
Policy Number ___________________________	Policy Number ___________________________
Group Number ____________ Effective date:________	Group Number ____________ Effective date:________
Policy Holder Information	**Policy Holder Information**
Name: ___________________________________	Name: ___________________________________
Address:_____________________________	Address:_____________________________
____	____
Phone Number: ________________________	Phone Number: ________________________
Relationship to patient:_____________________	Relationship to patient:_____________________
DOB:______________SS#:____________________	DOB:______________SS#:____________________
Employer:_________________________________	Employer:_________________________________

Saint Sophie's
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.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your **protected health information (PHI)**. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law (the Health Insurance Portability and Accountability Act of 1996 or HIPAA) to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights concerning your PHI
- Our obligation concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer: 3201 33rd St Fargo, ND 58104
Phone: 701-365-4488 Fax: 701-365-0727

C. Uses and Disclosures of Health Information

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other health care providers who are involved in taking care of you now or in the future.

We may also use health information about you to call you or send you a letter to remind you about an appointment, to follow up with diagnostic tests results, or to provide you with information about other treatment and care that could benefit your health.

For payment: We may use and disclose medical information about you so that the treatment and services you receive at the hospital may be billed and payment may be collected from you, an insurance company or a third party.

For healthcare operations: Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. Every effort will be made to insure anonymity

D. Other Disclosures

Business Associates: We will share your PHI with third party associates that perform various activities for the clinic. Whenever any arrangement between our clinic and a business associate involves the use of disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

Communication with others involved with your care: Our health professionals may, in the event you are incapacitated or in an emergency circumstance, using their judgment, disclose to a family member, or other relative, close personal friend or any other person you identify, health information directly relevant to that person's involvement in your care or payment related to your care.

Research: Under certain circumstances, we may use and disclose health information about you from your medical record for research purposes. All research projects, however, are subject to a special approval process designed to protect the privacy of your health information.

Required by law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such disclosures.

Public Health Risks: Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled or withdrawn, needs repairs or replacement
- Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are require or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

Health Oversight Activities: Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Legal Proceedings: We may disclose your PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal, in certain conditions in response to a subpoena, discovery request or other lawful purpose.

Law Enforcement: We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person.
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

Deceased Patients: Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

Organ and Tissue Donation: Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

Research: Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your PHI is being used only for the research and (iii) the researcher will not remove any of your PHI from our practice; or (c) the PHI sought by the researcher only relates to decedents and the researcher agrees in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the PHI of the decedents.

Serious Threats to Health or Safety: Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent or lessen the threat.

Military: Our practice may disclose your PHI if you are a member of the U.S. Armed Forces, a veteran, or a member of foreign military forces for activities deemed necessary by appropriate military commend authorities, including the Department of Veteran's Affairs for the purpose of your eligibility for or entitlement to certain benefits provided by law.

National Security: Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

Inmates: Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you (b) for the health, safety and security of the institution, and its officers and employees and/or (c) to protect your health and safety or the health and safety of other individuals.

Workers' Compensation: Our practice may release your PHI for workers' compensation and similar programs to the extent necessary to comply with applicable laws.

Required Uses and Disclosures: Under the law, we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirement of Section 164.500 et. seq.

We will **not** use information in your records for marketing purposes.

Other uses and disclosures from your medical record will be made only with your written authorization or approval.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, please use the contact information below to make an appointment to complete the form. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing using the contact information below. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records. However, you may not obtain psychotherapy notes or information compiled in reasonable anticipation of a civil, criminal or administrative action or proceeding. You must submit your request in writing using the contact information below in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by our practice.

To request an amendment, your request and reason for the request must be made in writing using the contact information below. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) was not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing using the contact information below. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date the "accounting of disclosures" is requested and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time by contacting us utilizing the contact information below.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint with our practice, use the contact information below.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: We are required to retain records of your care.

Contact Information:

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