Please note the following:

All forms must be filled out in full and brought to the first session. Please bring your insurance card if you planning to use insurance.

Be prepared to pay your copay or fees for counseling at the beginning of the session. If you chose to use a credit card to pay your fees/copay during your first session there may be an administrative delay while I set up your account. If you wish to avoid this delay you are free to bring cash or a check to the first session to cover your fees. After the first session you are free to use Visa, Mastercard, cash or check to pay your fees.

My goal is for your counseling to be a productive and meaningful experience from the very first session. If you have any concerns or questions regarding the forms required to begin counseling, please let me know immediately so I can answer your questions.

If you are going to use your insurance, it is very important to completely fill out the Regarding Your Insurance Benefits form. You will need to call your insurance company in order to certain of your copay, to determine any unpaid deductible that remains, and to insure that there have not been any changes to your mental health coverage since you last used it. Please use the Regarding Your Insurance Benefits form to assist you with gathering this information.

Again, it is crucial that you fill out all forms in full and bring them and any necessary items (insurance card, etc.) to your first session so that we can focus on you and the challenges you are facing instead of administrative issues.

I look forward to meeting you and helping you achieve your goals.

Sincerely,

Tina Marie Rees, MA, LPC
Practical Life Counseling

CLIENT INFORMATION FORM

Date: ____________________

SECTION 1: CLIENT (name of person to be seen by the therapist)

Name: ____________________

Mailing Address: ____________________

Home Phone: ____________________

Cell Phone: ____________________

May I leave a voice mail for you? Y N

Preferred phone number for contact: Home Cell

Date of Birth: ____________________

Gender: M F

Social Security #: ____________________

SECTION II: PERSONAL INFORMATION

FAMILY / MARITAL STATUS:  □ Single  □ Married  □ Widowed  □ Divorced  □ Separated

_______ number of children living at home with you, part-time or full-time

Names and ages of children or other residents living in your home other than yourself:

<table>
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<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship to You</th>
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CURRENT CONCERNS, OR REASONS FOR COMING TO COUNSELING:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Rev 06/2014
EMERGENCY INFORMATION: REQUIRED

In case of emergency, notify: Name: ____________________________ Relationship to you: ______________

Phone Number: ____________________________ □ Home □ Cell

***I will contact your emergency contact person in the event that you miss an appointment and do not contact me to reschedule; such an event indicates that you may be seriously ill or have harmed yourself and are in need of assistance.

REFERRAL: How were you referred to me? □ Friend □ Insurance □ Internet □ Minister

Other: ____________________________

SECTION III: FINANCIAL RESPONSIBILITY

Insurance Policy Holder (if other than client) OR Third Party responsible for payment (not client or insurance policy holder)

Name: ____________________________

Address: ____________________________

City / St / Zip: ____________________________

Home Phone: ____________________________ Cell: ____________________________ Work: ____________________________

Gender: M □ F □ Date of Birth: ____________ SSN #: ____________________________

Client’s relationship to this person: □ Self □ Spouse □ Child □ Other

SECTION IV: INSURANCE if you plan to use insurance, you must complete section II above

Insurance Co Name: ____________________________

Name of Mental Health Carrier: ____________________________

(if not the same as your general health insurance company)

Is Preauthorization required? □ Yes □ No (If yes or unsure, please obtain authorization PRIOR to the first session.)

Upon your request, I will bill your insurance company for you (you must pay any deductibles and/or copayments.) If preauthorization is required, you must obtain authorization PRIOR to the first session. Please know that verification of insurance benefits is not a guarantee of payment. Final determination is made upon receipt of claim and review of all documentation. If your insurance company denies payment for any reason, you will then be responsible for the amount due. By signing below, you authorize Practical Life Counseling to release any information required for processing claims and to receive benefits due under your policy for services rendered:

Client or responsible party must sign. Thank you.

Authorized Signature: ____________________________ Date: ____________________________

Rev 06/2014
### Comprehensive Medication List

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<th>Medication and Dosage</th>
<th>Why do you take this?</th>
<th>Frequency</th>
<th>Who prescribed this? Please circle one</th>
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Feelings, Thoughts, Experiences you are Having

Name: ____________________________  DOB: ______________________

Please check (v) the items below that apply; you may place an asterisk (*) by the most important ones. If it does not apply to you, please leave it blank.

☐ Cry easily
☐ Feel sad, blue
☐ Little interest in things
☐ Poor appetite / Overeating
☐ Poor sleep / sleeping too much
☐ Feel worthless
☐ Feeling low in energy
☐ Feel worthless

☐ Feel everything is hard
☐ Difficulty getting things done
☐ Trouble remembering things
☐ Mind going blank
☐ Blame self for things
☐ Feel inferior to others
☐ Feel easily annoyed
☐ Thoughts of ending your life
☐ Thoughts of death or dying
☐ Nervous
☐ Trembling
☐ Fearful
☐ Afraid of open spaces
☐ Afraid to leave house alone
☐ Feel uneasy in crowds
☐ Feel tense
☐ Feel restless

☐ Suddenly scared for no reason
☐ Spells of panic
☐ Nervous

☐ Racing heart
☐ Worry too much
☐ Difficulty making decisions
☐ Uneasy with the opposite sex
☐ Feel self-conscious with others

☐ Recurrent unpleasant thoughts
☐ Repeat behavior, like touching or washing
☐ Do things very slowly to insure correctness
☐ Double-check what you do
☐ Recurrent unpleasant memories
☐ Vivid dreams or nightmares
☐ Easily startled
☐ Avoid things, places, or activities because they frighten you

☐ Feeling that something bad is going to happen
☐ Feel criticized by others
☐ Feel people are unfriendly
☐ Feel others are to blame for most of your troubles
☐ Feel others do not understand you
☐ Feel others will take advantage of you
☐ Feel most people cannot be trusted
☐ Temper outbursts
☐ Frequent arguments
☐ Screaming or throwing things during conflict
☐ Feel out of control
☐ Never felt close to another person
☐ Feel lonely when with other people
☐ Thoughts about sex that bother you
☐ Feel nervous when alone
☐ Feelings easily hurt
☐ Idea that someone or something else can control your thoughts

☐ Hear voices
☐ See shadows
☐ Hear Knocking, footsteps, or other noises that others cannot hear

☐ Other people know your private thoughts
☐ See people or objects that others cannot see
☐ Feel you are being watched by others
☐ Other: ____________________________
Consent for Treatment

I understand that I will be engaging in psychotherapy at Practical Life Counseling with Tina Marie Rees, LPC. The purpose of this treatment is so that I feel better or resolve specific life or adjustment problems that have caused me to seek assistance. The primary procedure used by Ms. Rees is “talk” therapy, although I understand that she may also provide general education about mental health conditions or coping strategies. She is a Level Two EMDR practitioner and may use this technique with me. She may also assign “homework” for me to do in between sessions. The potential benefit of treatment is that I will feel better about my life. I understand that a “cure” is not guaranteed and that it is possible that as I talk about some things, I may even feel worse.

I understand that all information I share will be kept confidential, but that this confidentiality is not absolute. In the case of medical emergency, child/elder abuse or neglect, suicidal or homicidal intent, or under court order, clinical information may be released. I also understand that if my treatment is paid for by an insurance company, Ms. Rees will release clinical information to my insurer. Usually, only that information required for billing will be released, however, Ms. Rees must fulfill any and all requests for clinical information made by my insurance company.

I understand that as an independently licensed professional counselor in Arizona Ms. Rees is not obligated to receive clinical supervision. However, in an effort to provide services that reflect best practices, she belongs to a consultation group composed of other therapists that meets regularly and has also engaged a practice consultant with whom she discusses some clinical cases. I understand that if Ms. Rees discusses my case with the consultation group or with the practice consultant I will not be identified by name.

I understand that Ms. Rees will be texting me (or emailing me if I so request) to remind me of my scheduled appointment. I am not expected to respond to these appointment reminders. I also understand that Ms. Rees does not do counseling via email or text and will not respond to text messages or emails that deal with therapeutic issues. Ms. Rees and I will deal with therapeutic issues during counseling sessions and I am encouraged to maintain a journal or create a list of issues to bring with me to my counseling session to insure that my concerns are addressed in my counseling sessions.

I understand that I can receive a summary of treatment or a copy of my records or have a copy of my records provided to another person by completing a ‘Release of Information’ form. Ms. Rees retains the right to ask to meet with me prior to releasing any records or summary of treatment to anyone who is not a medical practitioner (i.e. my PCP, psychiatrist, or another counselor) in order to insure that I understand the implications of releasing my records to non-medical personnel. I understand that I will be required to pay for this session and that my insurance may not cover this session as it may not be therapeutic in nature.

I understand that I have the right to participate in treatment decisions and that Ms. Rees and I will together develop and periodically review and revise a treatment plan which will identify my goals for treatment as well as the means of achieving those goals. I understand that I have the right to refuse any recommended treatment and that I may withdraw my consent to treatment at any time with no consequences. I understand that if I do not attend a counseling session with Ms. Rees for a period of 45 consecutive days without making prior arrangements with Ms. Rees for this absence that the counseling relationship will be terminated; should this occur, I understand that I will be informed of the termination in a letter. I understand that I have the right to ask for a referral to another counselor should I require counseling that is outside of Ms. Rees’s scope of practice or if I should decide to terminate counseling with Ms. Rees and seek treatment from another counselor. I also understand that Ms. Rees will immediately provide referrals to other counseling sources should she discover that my needs are outside of her scope of practice. I understand that it is my responsibility to attend sessions with another counselor should my needs be outside of Ms. Rees’ scope of practice. If I refuse to seek another counselor despite Ms. Rees’s recommendation that I do so, I realize that Ms. Rees has the right to refuse to treat any and all needs outside her scope of practice or to terminate our counseling relationship.
Consent for Treatment

Ms. Rees does not testify in court for clients at their request or at the request of their legal representative. Any and all requests for testimony must be made through the order of a judge requiring Ms. Rees to testify in court either on my behalf or on the behalf of the prosecution. If I wish for my clinical records or a summary of sessions to be released to my legal representative or to the prosecution, I must authorize this release on a Release of Information form specifically. I understand that I assume all legal liability for any authorized release of records. Ms. Rees cannot be held legally liable for any clinical records released by order of a judge.

I understand that I have the right and am encouraged to discuss any concerns or dissatisfaction I have with my experiences in counseling with Ms. Rees. I understand that any grievances I share with Ms. Rees will be addressed in session and Ms. Rees will do her best to resolve these grievances to my satisfaction. I understand that I have the right to terminate counseling and receive referrals to other counselors if these concerns cannot be resolved to my satisfaction.

I understand that the fees for counseling are $120 for a regular session and $180 for an intake session. I understand that if I do not have insurance, I have the right to ask for these fees to be adjusted to account for certain challenges in my life that are outside of my control. I understand that Ms. Rees is not required to adjust my fee and that any adjustment to my fee will be regularly reviewed.

If I will be using my insurance to pay for my counseling, I understand that Practical Life Counseling will bill my insurance company at the standard fee of $120 for a regular session and $180 for an intake session and will accept insurance payments as partial payment towards this fee. I will be responsible for paying the agreed upon co-pay or co-insurance for each session covered by the insurance. Any excess insurance payments to Ms. Rees will be credited to my account and any insurance payments sent to me will be remitted to Ms. Rees up to the amount of my unpaid balance. Failure to do so will result in immediate charges to my credit card for the balance. I have been provided with and read the Policy for Secured Appointments. I understand that my insurance company is under contract with me and/or my employer and that I am ultimately responsible for all charges incurred for services at Practical Life Counseling.

My signature below signifies that I have received a copy of my HIPAA rights and had any questions I may have had answered to my satisfaction; that Ms. Rees has the right to bill my insurance company if I am using insurance; and that I have read the above information and consent for treatment.

Signature: _______________________________ Date: __________________

Guardian Signature (for minors only): _______________________________ Date: __________________

Witness: _______________________________ Date: __________________
Policy for Secured Appointments

All clients must secure future appointments by providing a valid and current credit or debit card. The card number and expiration date will be stored in the client's file until the client terminates the counseling relationship. The credit/debit card information will only be used in the event that the client misses an appointment or cancels the appointment with less than 24 hours notice. **You will be charged $120 (or your negotiated private pay fee) for missed appointments and late cancellations.** Charges for late cancellations and missed appointments will be automatically charged to the client’s credit/debit card.

Clients paying for appointments with checks will incur a $25 fee for NSF checks. The balance of the unpaid session and the $25 NSF fee will be automatically charged to the client’s credit/debit card.

Clients are required to provide updates of credit/debit card information to their clinician one month prior to the expiration of the provided credit/debit card. Failure to do so will result in the loss of scheduled appointments until credit/debit card information is updated with valid and current information.

At termination of the counseling relationship, the client’s credit/debit card information will be destroyed. Clients who wish to reenter counseling after previous termination will need to supply current credit/debit information to secure appointments.

Clients using insurance: **If your insurance company denies payment for any reason that is within your control (does not reflect an error on my part) or if the amount charged is credited to your deductible, you will be responsible for the amount due.** Failure to make payment arrangements within 30 days of notification that your insurance company has denied payment will result in immediate charges to your credit card/debit card for the amount due. Insurance payments that are sent to you must be promptly remitted to Practical Life Counseling up to the amount of your balance. Failure to do so will result in charges to your credit card/debit card for the amount due.

Receipts for automatic charges made to the client’s credit/debit card will be made available to the client either at the time of the client’s next appointment or by mail.

**Unpaid balances that cannot be collected through provisions for secured appointments and that remain unpaid for over sixty (60) days may be turned over to a collection agency.**

Please read and sign below:

I agree to provide Practical Life Counseling with credit card/debit card information that is current and valid. I understand that charges for balances owed may be made to my credit/debit card at any time. If I have questions about these charges, I am entitled to a full explanation and proof of moneys owed; these will be provided by Practical Life Counseling and/or my insurance company. I understand that I will be charged the fee designated above for all missed appointments or late (less than 24 hour) cancellations of appointments.

Authorized Signature: ___________________________ Date: ______________

Credit Card Number: ___________________________ (Mastercard or Visa only)

Expiration Date: _____ / _____ (mm/yyyy) CCV _____ (on back of card)

Rev 9/4/2014

Tina Marie Rees
Authorization for Release of Information

Name of Client: ___________________________ Date of Birth: ________________

If client is a minor, name of parent/guardian: _______________________________________

I hereby authorize Tina Marie Rees, LPC and Practical Life Counseling to exchange information about my mental and physical health with:

Name: ____________________________________________

(Name of individual, Physician, Practice, or Therapist)

Address __________________________________________

Phone: __________________________ Fax: __________________________

Information to be exchanged may include summary of treatment; diagnosis; attendance and dates of attendance; psychological evaluation / test results; medical health records; and progress notes. This information, if exchanged, will be used to coordinate and increase the quality of my care.

I understand that my clinical treatment records may be protected by federal regulations that may determine the extent and nature of the information that may be disclosed pursuant to this authorization. I do hereby give this consent to the release of the records described above freely and voluntarily, and acknowledge that I am not under and force or duress. I further understand that the provision of treatment and care will not be denied by reason of refusal to sign this consent form.

I understand that Ms. Rees’ policy is to release only that information about a client/former client, which, in her judgment, is considered essential for the coordination of care or continuation of care. The authorization does not obligate Tina Marie Rees or Practical Life Counseling to open my records for inspection, or to otherwise provide information which may violate the above policy.

I release Tina Marie Rees and Practical Life Counseling from any and all legal liability that may arise from the disclosure of the information requested.

This consent will terminate __/__/____ or one year after the date this form is signed. Any release of my clinical treatment records beyond that date will require me to sign another authorization for release of information.

Authorization for release of information may be revoked in writing at any time.

☐ In such cases as is necessary, I authorize Practical Life Counseling to fax my treatment records.

_________________________________________ ________________________
Signature of Client, Parent/Guardian Date

_________________________________________ ________________________
Signature of Therapist Date

Rev: 4/26/2014
Regarding Your Insurance Benefits

Because your insurance policy is an agreement between you and your contracted insurance company, it is important that you call your insurance company to determine what your mental health benefits are prior to receiving treatment from our office.

This form was created to assist you in getting your insurance questions answered and to help you understand your covered mental health care benefits. Feel free to ask your insurance representative any additional questions you may have.

Please print this form and record the information on it. Bring the completed form with you to your appointment.

(It will be helpful to you to record the name of the representative, the time, and date of when you spoke with him/her.)

Name of patient services representative

Date you called: ___________________ Time you called: ___________________

1. Tell the representative: "I am calling to check my mental health benefits."
2. Ask what company handles your mental health benefits.

3. If not the company displayed on your insurance card (separate from your medical benefits), please record the info here:
   a. Name: ___________________________ Phone Number: ___________________________

4. Is Tina Marie Rees, MA, LPC “in-network” or “out of network”? __________________

Benefits:

Co-pay __________ or Co-insurance? _____________ Deductible? $ _____________

Has any part of the deductible been met for this year? Yes/No If yes, how much? $ ______

If an Authorization is required, you MUST have the authorization number to begin counseling.

   Auth# ___________________________ # of visits ___________________________
   Effective Dates: From: ___________________________ To: ___________________________

   Type of authorization: Regular Mental Health_______ EAP ________


This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of my responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information I have about you. 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.

Ask me to correct your medical record
- You can ask me to correct health information about you that you think is incorrect or incomplete. Ask me how to do this.
- I may say “no” to your request, but I’ll tell you why in writing within 60 days.

Request confidential communications
- You can ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- I will say “yes” to all reasonable requests.

Ask me to limit what I use or share
- You can ask me not to use or share certain health information for treatment, payment, or my operations. I am not required to agree to your request, and I may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask me not to share that information for the purpose of payment or my operation with your health insurer. I will say “yes” unless a law requires me to share that information.

Get a list of those with whom I’ve shared information
- You can ask for a list (accounting) of the times I’ve shared your health information for six years prior to the date you ask, who I shared it with, and why.
- I will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked me to make). I’ll provide one summary of all disclosures at no cost to you each year but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

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. I will provide you with a paper copy promptly.
YOUR INFORMATION, YOUR RIGHTS, MY RESPONSIBILITIES

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information
- I will make sure the person has this authority and can act for you before I take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting me. I will listen to all of your complaints and respond in writing within 30 days.
- 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 Avenue, SW, Washington, DC 20201 or by calling 1-877-696-6775.
- 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 the situations described below, talk to me. Tell me what you want me to do, and I will follow your instructions.

In these cases, you have both the right and 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

If you are not able to tell me your preference, for example if you are unconscious, I may 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.

I will never sell your information for marketing purposes, nor will I share your psychotherapy notes unless you give me written permission.

USES AND DISCLOSURES

How do I typically use or share your health information? I typically use or share your health information in the following ways:

Treat you
I can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run my practice
I can use and share your health information to run my practice, improve your care, and contact you when necessary.
Example: I use health information about you to manage your treatment and services.

Bill for your services
I can use and share your health information to bill and get payment from health plans or other entities.
Example: I give information about you to your health insurance plan so it will pay for your services.
YOUR INFORMATION, YOUR RIGHTS, MY RESPONSIBILITIES

How else can I use or share your health information?
I am allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. I have to meet many conditions in the law before I can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues
I can share health information about you for certain situations. These situations are all defined by law:
- If you are a danger to yourself or have threatened the safety of others
- If you are abusing a child or a vulnerable adult/elderly person
- Reporting suspected abuse, neglect, or domestic violence

Comply with the law
I will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that I am complying with federal privacy law.

Work with a medical examiner
I can share health information with a coroner or medical examiner when an individual dies.

Address workers’ compensation, law enforcement, and other government requests
I can use or share health information about you:
- For workers’ compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
I can share health information about you in response to a court or administrative order, or in response to a subpoena.

My Responsibilities
- I am required by law to maintain the privacy and security of your protected health information.
- I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- I must follow the duties and privacy practices described in this notice and give you a copy of it.
- I will not use or share your information other than as described here unless you tell me in writing that I can. If you tell me that I can share your information, you may change your mind at any time. Let me know in writing if you change your mind.

Changes to the Terms of this Notice
I can change the terms of this notice, and the changes will apply to all information I have about you. The new notice will be available upon request, in my office, and on my web site.

This notice is effective as of 9/1/2014.