CHILD INTAKE FORM
(Please complete in Ink)

CHILD

1. Child's Name_____Sex_____Age_____DOB_____
2. Natural Child Yes / No If adopted, at what age_____Foster since _____
3. Parent's Names (include step-parents, foster parents, etc.)

   _____

   _____

4. Comments about custody and visitation (if applicable):

   _____

   _____

5. Primary reason you are concerned about your child?

   _____

   _____

   _____

SYMPTOM/PROBLEM CHECKLIST

Check any symptom that is a concern. How long has it been a problem?

a. __ Sleep problems
_____Lack of interest in activities
_____Unassertive
_____Fatigue/low energy
_____Concentration problems
_____Appetite/weight changes
_____Withdrawal

_____Morbid thoughts
_____Suicidal thoughts or threats
_____Suicidal plans / attempts
_____Mood swings
_____Depression
_____Changed level of activity
_____Cries easily

b. __ Forgetful/memory problems
____Short attention span
____Aggressive behavior
____Can't sit still
____Not interested in peers
____Picked on / bullied by peers

_____Talks excessively / interrupts
_____Easily distracted
_____Irritable
_____Impulsive
_____Difficulty following rules
_____Problem completing schoolwork

c.
- _____ Excessive worry / fearfulness
- _____ Anxiety or panic attacks
- _____ Social fears, shyness
- _____ Separation problems
- _____ Bedwetting / soiling
- _____ Headaches, stomachaches
- _____ Odd beliefs / fantasizing
- _____ Nightmares
- _____ Frequent tantrums
- _____ Resistive to change
- _____ School refusal
- _____ Perfectionism
- _____ Odd hand / motor movements
- _____ Hallucinations

d.
- _____ Lying
- _____ Trouble with the law
- _____ Running away
- _____ Truancy, skipping school
- _____ Hurting others sexually
- _____ Alcohol / drug use
- _____ Argumentative / defiant
- _____ Swears
- _____ Blames others for mistakes
- _____ Stealing
- _____ Being destructive
- _____ Fire setting
- _____ Hurting others / fighting
- _____ Acts as if has no fear
- _____ Short tempered
- _____ Easily annoyed / annoys others
- _____ Discipline problem
- _____ Angry and resentful

Brothers and Sisters

First Name – Last Name	Sex	Age	Relationship to child (full, step, half, foster)
1.			
2.			
3.			
4.			
5.			
6.			

SCHOOL HISTORY

1. Present School:_____Grade:_____Teacher:_____
2. Has child ever repeated any grade? _____
3. Is child in special education services? No_____Yes, what kind? _____
4. Please describe academic or other problems your child has had in school

_____

CHILD'S DEVELOPMENTAL AND MEDICAL HISTORY

1. Pregnancy

Mother used during pregnancy: alcohol_____drugs_____cigarettes _____

Delivery: Normal_____Breech_____Cesarean_____Transectional_____
Full-term_____Premature_____if premature, number of weeks _____

Birth Weight: _____

Problems at birth: (for example: infant given oxygen, blood transfusion, placed in an Incubator, etc)

_____

2. Developmental History

- State approximate age when child did the following:

  Walked alone_____Said first word_____Used 2-word phrases _____

- Understood and followed simple directions _____
- Reasonably well toilet trained _____
- Did child cry excessively?_____Rarely cried _____

3. Health History of Child

In the first two years, did your child experience:_____Separation from mother,

___Out of home care,____Disruption in bonding,____Depression of mother, ___Abuse,

___Neglect,____Chronic pain,____Chronic Illness, _Parental Stress

- Child's Doctor: _____
- Date of last physical exam: _____
- Vision problems? Yes_____No_____Hearing problems? Yes_____No _____
- Dental problems? Yes_____No _____
- Any head injuries or loss of consciousness? Yes_____No _____
- Child's history of serious illness, injury, handicaps, or hospitalization?

  No_____ Yes – describe and give dates _____
- Is your child currently taking any medications? No_____Yes_____name medications

_____

- List any medicines previously used for emotional problems: were they helpful? _____

  _____

- Allergies to drugs or medicines? No_____ Yes_____ (list) _____
- Allergies to any foods? No_____ Yes_____ (list) _____
- Are there any foods that you limit or do not give this child? No_____ Yes _____

  (list)_____.
- Allergies to environmental conditions? No_____ Yes____ (list) _____
- Does anyone in the household smoke? No_____ Yes _____
- About how many hours does this child watch TV, videos, etc per day _____
- Are you afraid someone you know may injure/harm this child? No_____ Yes _____

  National Domestic Violence Hotline 1-800-799-7233
- Does this child have a Health Care Directive? No_____ Yes _____

  If yes, please list where (clinic) it is on file _____
- Any previous psychological or psychiatric treatment? No_____ Yes _____

  Whom/where_____ when_____
- Any previous testing (school/psychological)? No_____ Yes _____

  Whom/where_____ when_____
- Do you think your child's use of chemicals is a problem? No_____ Yes _____

  Type: Alcohol_____ Marijuana_____ Other drugs _____

  Comments: _____

Family History:

Chemical use (now & past): No_____ Yes_____ Which parent _____

Type: Alcohol_____ Marijuana_____ Other drugs_____

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):

_____

_____

Has child witnessed domestic violence?___Y,___N, Specify: _____

_____

How is your child disciplined? Please list each method and frequency ofuse: _____

_____

_____

LIFE STRESSORS/TRAUMA HISTORY

1. Has your child been verbally abused?___Y,___N,___Suspected. Specify: _____

_____

2. Has your child been physically abused?__ Y,___N, Suspected. Specify: _____

_____

3. Has your child been sexually abused?___Y,___N,___Suspected. Specify: _____

_____

4. Other stressors or traumas?_____

_____

What are your child's strengths?

Any additional comments or information that would be helpful to us?

Signature of person completing form / relationship to client:

_____Date:_____

Name Relationship

Parent Form

Section 1: Print Clearly

Full Name: _____

Address: _____

Home Phone:_____Work Phone:_____Cell Phone: _____

Married____Single___Divorced___Your email:_____Spouse email: _____

Preferred Phone Contact Number:_____Sex:____M____F Date of Birth:____/____/____

Race:_____White_____Black_____Hispanic_____Asian_____Other

Ethnicity:_____Puerto Rican_____Mexican_____Cuban_____Other_____Not of Hispanic Origin

Highest Grade Completed:_____Family Income:_____per year

Employee Status:_____Full-Time_____Part-time_____Homemaker_____Unemployed_____Retired/ Disable

Source of Income:_____Wages/Salary_____Retirement/Pension_____Public Asst._____Self-Employment

Living Arrangements:_____Homeless_____Dependent Living_____Independent Living

Number of Children:_____Currently Pregnant? Yes / No Tobacco Use Past 30 days? Yes /No

Use of illegal drugs past 30 days? Yes/ No Do you use alcohol? Yes / No How many times/week? _____

How many drinks do you have per occasion?_____Have you ever been arrested? Yes / No # ofArrests? _____

Reason for Arrest(s)? _____

In case of emergency, please contact:

1. _____/_____/_____ (Contact Name/ Phone/ Relationship)

2. _____/_____/_____ (Contact Name/ Phone/ Relationship)

Section 2:

Reason for appointment at Bay Area Christian Counseling

1. Self-Referral *_____2. Attorney Referred*_____3. Court Referred*_____4. Other _____
   *Please list referral source: _____
   Presenting Problem: _____

   I or a family member are currently seeing a:
   Counselor_____2. Psychologist_____3. Psychiatrist_____4. Other _____
   Reason for seeing above professional:
   _____
   Current Mental Health Problems: yes / no Diagnosis:_____
   Please check any of the following that you suffer from:
   _____Trouble getting out of bed _____Difficulty working w/ others_____Difficulty staying focus
   _____Over/Under Eating Difficult Relationships _____Frequent Worrying_____Depression
   List anything else you'd like your clinician to know:
   _____
   _____

Patient Signature (or Legal Guardian)_____Date:_____

INFORMATION FORM

Full Name:_____Birth Date: _____

Parent SS #:_____Driver's License #: _____

Employer Name:_____Employer Address: _____

Occupation: _____

Emergency Contact Person:_____Phone: _____

Name of Spouse or Parent/Guardian: _____

Referring Doctor (if applicable):_____Phone: _____

Primary Care Doctor:_____Current Medication and Dosage: _____

_____

_____

Insurance Information

Please present ALL insurance cards and Driver's License to the clinician.

PRIMARY:_____MBR ID#:_____Group#: _____

Policy Holder Name/Relationship:_____Co-Payment amt.: _____

Policy Holder Date of Birth:_____Policy Holder SS#: _____

SECONDARY:_____MBR ID#:_____Group#: _____

Policy Holder/ Relationship:_____Co-Payment amt.: _____

Policy Holder Date of Birth:_____Policy Hold SS#: _____

Guarantor Name: (Person responsible afterinsurance): _____

Relationship:_____Address: _____

Home Phone:_____Work Phone:_____Cell: _____

ASSIGNMENT, RELEASE, and HIPPA COMPLIANCE

I hereby assign all medical benefits to which I am entitled to Bay Area Christian Counseling for services rendered by Bay Area Christian Counseling. This will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure payment. I hereby assume all financial responsibility for all charges whether or not paid by said insurance. I further understand that all balances due are to be paid within 30 days of receipt of Statement. I also acknowledge that this office is HIPPA compliant, and that all efforts will be made to ensure my privacy, and that all records and copies of HIPPA privacy practices are available to me upon request.

_____ _____

Patient Signature (or Legal Guardian) Date

Confidentiality of Patient Records

Client Name: _____

Social Security #: _____/_____/_____ Date of Birth: _____

Federal law and regulations protect all confidential patient records maintained by this agency. The staff or counselors will not say to a person outside the agency that a patient attends counseling or disclose any information identifying the patient unless:

1. The patient consents in writing,
2. The disclosure is allowed by court order,
3. The disclosure is made to medical/police personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation, or

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

I have received and understand the above reference to my confidentiality right at Bay Area Christian Counseling, Inc. I am aware that Bay Area Christian Counseling, Inc. does not communicate via e- mail, text, or cell phone unless utilizing our secure online counseling services located at www.bayareachristiancounseling.org . I further understand that this form and my signature are to become a permanent part of my record at Bay Area Christian Counseling, Inc.

Client/Guardian Signature: _____ Date: _____

Clinician Signature: _____ Date: _____

102 Old Solomons Island Road, Suite 202
Annapolis, MD 21401-3879

PARENTAL CONSENT FOR TREATMENT

I,_____, hereby authorize Bay Area Christian Counseling, Inc. to provide mental health counseling and/or treatment to_____, date of birth_____, a minor. This authorization is effective immediately and remains in force and effect unless and until I revoke it in writing.

In providing this authorization, I state the following:

_____ I am the natural or adoptive parent of the minor and there are no court orders in effect regarding legal custody or the ability of any person to authorize mental health counseling or treatment; or

_____I am the entitled by Court order to authorize mental health counseling or treatment (a copy of that Order is attached) and I am not aware of any subsequent Court orders; or

I understand that Bay Area Christian Counseling, Inc. and its employees and agents have relied upon this Consent form in agreeing to render counseling and/or treatment to the minor and I will indemnify and hold them harmless in the event the statements above are not true or accurate.

_____ _____

Date Authorizing Person

Ability to Pay Form

Client and Parent Name: _____

***Fee charged for Service*:** 60 Minute Intake = $135.00 60 Minute Session = $115.00

50 Minute Family Session with Patient = $100.00 50 Minute Individual Session = $80.00

50 Minute Family Session without Patient = $80.00 30 Minute Session = $60.00

Fee charged for Court Appearance $200.00/per hour, **4 hour minimum**
Report Preparation Fee $150.00/per report
Forms & Letters: $25 to $75 depending on detail/time

Phone calls: A fee of $15 will be charged for any call lasting longer than 15 minutes not to exceed 20 minutes. Any longer time frame a session should be scheduled.

Our fees are subject to change without written notice.

Program justification for reduction of client fee (i.e. insurance co-pays):

I authorize Bay Area Christian Counseling or designated third party billing agency, holder of my medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable to related services. Please note: Co-pay/co-insurance is subject to change at any time. For further co-pay/ co-insurance information please contact your insurance company. I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim.

In addition, I understand that it is my responsibility to provide accurate insurance information if I intend to use my insurance coverage. If for any reason my insurance company does not cover or pay for my services within 45 days, I agree to pay for all services rendered. Our policy is not to have any client exceed a $250 balance.

I also understand that a 24-hour cancellation notification is necessary for canceling or rescheduling an appointment. If 24-hour* notification is not given, I understand that I am required to pay a $55.00 fee for my missed appointment(s). Any no call/no show missed fee is $80.00. Those fees and balances over 90 days will be charged to the following credit card:

Type of Card: VISA or MasterCard or American Express or Discover

Credit Card Number:_____Exp. Date: _____

Security Code (3 digit # on back) _____ : American Express Security Code (4 digit #) _____

Card Holder Signature: _____

I am aware Bay Area Christian Counseling charges a returned check fee of $25 and a $10 administrative fee for any declined credit card. In addition, if a check is returned or credit card is declined payment for all future services must be paid by cash or Money Order. Bay Area Christian Counseling's policy states all monies are due for service within 30 days of notification and any account sent to collections is subject to a $50.00 administrative fee and/or a 35% collections fee.

Client/Guardian Signature:_____ Date: _____

Clinician Signature:_____ Date: _____

RELEASE AND/OR OBTAIN INFORMATION FORM

I AUTHORIZE BAY AREA CHRISTIAN COUNSELING TO RELEASE/OBTAIN INFORMATION CONCERNING MY TREATMENT TO/FROM

_____

For Client: _____

REGARDING THE FOLLOWING INFORMATION:

_____Initial Interview _____Psycho-Social History

_____Counselor's Notes _____Discharge Summary

_____Medical History, Physical Exam, _____Disability Report or Forms Laboratory Reports

Other (Specify): _____

I WOULD LIKE THIS INFORMATION FORWARDED BECAUSE:

_____It will contribute to a comprehensive treatment plan for me.

_____It will provide information to my insurance company r third party payees as needed for billing.

Other reasons (Specify): _____

I understand that my treatment records are protected under Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for by Regulations. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it (e.g. probation, parole, court ordered, etc.). I also understand that this consent expires automatically at the completion of the disclosure unless specifically provided for the following date, event or condition, which marks the expiration of consent:

DATE CONSENT INITIATED: _____

Client/Guardian Signature & Date: _____

Witness Signature & Date: _____

PROBATION OF REDISCLOSURES

This information has been disclosed to you from records whose confidentiality is protected by Federal Law, Federal Regulations (42CFR, Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical information is NOT sufficient for this purpose.

Notices of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information. Please review this notice carefully.

A. Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your individually identifiable health information also called protected health information, or 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 to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with the 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 in your PHI,
Our obligations, 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 of maintained in the past, and for any of your records that we 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 Jim Stafford, ExecutiveDirector.
C. We may use and disclose your PHI in the followingways:
The following categories describe the different ways in which we may use and disclose your PHI
1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood and urine) tests and we may use the results to help us reach a diagnosis or to provide comprehensive treatment. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice including, but not limited to, our clinicians and assistants may use or disclose you PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to other Health care providers for purposes related to yourtreatment.
2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We may also use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose you PHI to other health care providers and entities in their billing and collection efforts.
3. Healthcare Operations. Our practice may use and disclose you PHI to operate our business. As examples of the way in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of your care you received from us, or to conduct cost management and business planning activities for our practice. We may disclose you PHI to other health care providers and entities to assist in their health care operations.
4. Appointment Reminders. Our practice may use and disclose you PHI to contact you and remind you of yourappointment.
5. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options and alternatives.
6. Health-related Benefits & Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
7. Release of Information to Family/Friends. Our practice may use or disclose your PHI to family members or a friend that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the counselor/psychiatrist for a mental health appointment. In this example, the baby sitter may have access to this child's medical information.
8. Disclosure Required by Law. Our practices will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certaincircumstances.
1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purposes 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 communicabledisease,
   - 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 beenrecalled,
- Notifying appropriate government agency (i.e.) and authorities regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or medical surveillance.

2. Health Oversight Activities. Our practices may disclose your PHI to a health oversight agency for activities authorized by the 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.
3. Lawsuits & similar proceedings. Our practice may disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceedings. We also may disclose our PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. Law Enforcement. We may disclose your PHI if asked by a law enforcementofficial:
   - Regarding a crime victim in certain situation, if we are unable to obtain the person'sagreement,
   - Concerning a death, we believe has resulted from a criminalconduct,
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, court order, subpoena, or similar legalprocess,
   - To identify/locate a suspect, material witness, fugitive or missingperson,
   - 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).
5. Deceased patients. Our practice may release your PHI to the medical examiner or coroner to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform theirjobs.
6. Organ & tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, include organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
7. 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 an Internal Review Board or Privacy Board has determined that the waiver of our authorization satisfies all of the followingconditions:
   a. The use or disclosure involves no more than a minimal risk to our privacy based on the following: (i) a adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other per or entity (except as required by law) for authorized oversight of the research study. Or for other research for which the use of disclosure would otherwise be permitted;
   b. The research could not practicably be conducted with thewaiver,
   c. The research could not practicably be conducted without access to and use pfPHI
8. 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 thethreat.
9. Military. Our practice may use and disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. 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.
11. Inmates. Our practice may disclose you 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 safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals.
12. Workers compensation. Our practice may release you PHI for workers" compensation and similar programs.

E. Your rights regarding 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 you must make a written request to Jim Stafford, Executive Director specifying the requested method of contact, or the location where you wish to be contacted. 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 of 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 a request in writing to Jim Stafford, Executive Director, 102 Old Solomons Island Rd, Ste 202, Annapolis, MD 201401. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure orboth,
- To whom you want the limits to apply.

3. Inspections & Copies. You have the right to inspect and obtain a copy of your PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Jim Stafford, Executive Director, 102 Old Solomons Island Rd, Ste 202, Annapolis, MD 21401 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 in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conductreviews.
4. Amendment. You make 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 or for our practice. To request an amendment, your request must be in writing and submitted to Jim Stafford, Executive Director, 102 Old Solomons Island Rd, Ste 202, Annapolis, MD 21401. You must provide us with a reason that supports your request for the amendment. Our practice will deny your request if you fail to submit your (and the reason for 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 kept of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to insect and copy; or (d) not created by our practice, unless the individual or entity that created the information was 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 purposes not related to treatment payment or operations. Use of your PHI s part of the routine patient care is 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 to Jim Stafford, Executive Director, 102 Old Solomons Island Rd, Ste 202, Annapolis, MD 21401. All requests for an "accounting of disclosures" must state a time period, which may not be longer that sic years from the date of disclosure and may not include dates before August 2015. The first list you request within a 12-month period is free of charge, but our practice must 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 copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice contact Jim Stafford, ExecutiveDirector.
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. To file a complaint with our practice, contact Jim Stafford, Executive Director. All complaints must be submitted in writing. You will not be penalized for filing acomplaint.
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 yourcare.

Again, if you have any questions regarding this notice of our health information privacy policies, please contact us at 410.266.3058.

Client/Guardian Signature HIPPA Disclosure **Date**

Clinician Signature **Date**