Welcome to Bay Area Christian Counseling, Inc. Please note that the information is important for your care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM **(ages 12-17)**

Adolescent please fill out pages 1-3, parent/guardian please fill out pages 4-18

CLIENT INFORMATION

Name: _____

Date of Birth: _____ Age: _____ ❒ Male ❒ Female

Complete Address_____

Phone (Cell): _____Messages okay?___ Text reminder okay?_____

School: _____ Grade: _____ Please

Share electronic communication (FaceBook, Twitter, SnapChat, Instagram, etc) that you use:

_____

Do your parents have access to your electronic communication? (Y/N) _____Do they have any issues with your use of phone, text, electronic communication? (Y/N) _____

EMERGENCY CONTACTS (Must complete)

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

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try? _____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe) _____

_____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking to have counseling for? _____

_____ What would you like to see happen as a result of counseling? _____

_____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? ❒ Yes ❒ No

If yes, what did you find **most helpful** in therapy? _____

_____

If yes, what did you find **least helpful** in therapy? _____

_____

CHEMICAL USE AND HISTORY

Do you currently use alcohol? _____Yes, _____No

If yes, how often do you drink? _____Daily, _____Weekly, _____Occasionally, _____Rarely If yes, how much do you drink? _____(#) per time.
Do you currently use Tobacco? _____Yes, _____No
If yes, how much do you smoke/chew? _____
Do you currently use any other drugs? _____Yes, _____No
If yes, what drugs do you use? _____
If yes, how often do you use? _____Daily, _____Weekly, _____Occasionally, _____Rarely
Have you received any previous treatment for chemical use? Y/N _____
If so, where did you go?_____
____Inpatient _____Outpatient

Adolescents (*please answer the following with* **Y/N)**

1. Have you ever used more than 1 chemical at the same time to get high? _____
2. Do you avoid family activities so you can use? _____
3. Do you have a group of friends who also use? _____
4. Do you use to improve your emotions such as when you feel sad or depressed?? _____

LEGAL ISSUES

Have you ever been arrested? Yes / No # of Arrests?____
Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past._____

FAMILY HISTORY

1. Are your parents married or divorced? _____
2. Do you think their relationship **is** good? (Y/N/Unsure)_____
3. If your parents are divorced, whom do you primarily live with? _____
4. How often do you see each parent? Mom_____% Dad _____%.
5. Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

_____

_____

FAMILY CONCERNS (*Please check any family concerns that your family is currently experiencing*)

	fighting		Disagreeing about relatives
	feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a sibling
	Abuse/neglect		Birth of a child
	Inadequate housing/feeling unsafe		Inadequate health insurance
	Job change or job dissatisfaction		Other

Other concerns not listed above _____

PEER RELATIONS

1. How do you consider yourself socially: ___outgoing ____shy ____depends on the situation.
2. Are you happy with the amount of friends you have? (Y/N)_____
3. Have you ever been bullied? (Y/N) _____
4. Are your parents happy with your friends? (Y/N)_____
5. Are involved in any organized social activities (e.g. sports, scouts, music)? _____

SCHOOL HISTORY

1. Do you like school? (Y/N)_____
2. Do you attend regularly? (Y/N)_____
3. What are your current grades? _____
4. Do you feel you are doing the best you can at School? (Y/N) _____

INDIVIDUAL CONCERNS

SYMPTOM	NONE	MILD	MOD	SEVERE		SYMPTOM	NONE	MILD	MOD	SEVERE
SADNESS						APPETITE CHANGES				
CRYING						SOCIAL ISOLATION				
SLEEP DISTRUBANCES						PARANOID THOUGHTS				
PROBLEMS AT HOME						POOR CONCENTRATION				
HYPERACTIVITY						INDECISIVENESS				
BINGING/PURGING						LOW ENERGY				
LONELINESS						EXCESSIVE WORRY				
UNRESOLVED GUILT						LOW SELF WORTH				
IRRITABILITY						ANGER ISSUES				
NAUSEA/INDIGESTION						SPIRITUAL CONCERNS				
SOCIAL ANXIETY						HALLUCINATIONS				
SELF MUTALATION						RACING THOUGHTS				
CUTTING						RESTLESSNESS				
IMPULSIVITY						DRUG USE				
NIGHTMARES						ALCOHOL USE				
HOPELESSNESS						EASILY DISTRACTED				
ELEVATED MOOD						TRAUMA FLASHBACKS				
MOOD SWINGS						OBSESSIVE THOUGHTS				
DISORGANIZED						PANIC ATTACKS				
ANOREXIA						FEELING ANXIOUS				
GRIEF						FEELING PANICKY				
PHOBIAS						SUICIDAL THOUGHTS				
HEADACHES						PAST SUICIDE ATTEMPTS				
WEIGHT CHANGES (UNPLANNED CHANGES)						OTHER				

Welcome to Bay Area Christian Counseling, Inc. Please note that the information is important for your child's care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM (PARENT SECTION)

(Emergency Contacts on 1st page must be completed)

Adolescent's Name: _____

Date of Birth: _____ Age: _____ ❒ Male ❒ Female

Race/Ethnic Origin: _____

Religious Preference: _____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name	Relationship (parent, sibling, etc)	Age	Sex	Type (bio, step, etc)	Living with you? Y/N

(If additional space is need please add additional pages)

Current Reason For Seeking Counseling For Your Adolescent.

Briefly describe the problem for which your adolescent is seeking to have counseling for?

_____

_____

What would you like to see happen as a result of counseling? _____

_____ What is most concerning right now? _____

_____

CHILD'S DEVELOPMENT

1. Were there any complications with the pregnancy or delivery of your child? Yes ___ No ___ If yes, describe:
   _____
2. Did your child have health problems at birth? Yes _____ No _____
   If yes, describe: _____
3. Did your child experience any developmental delays (e.g. toilet training, walking, talking)?
   Yes ___ No ___ Not sure_____
   If yes, describe: _____

4. Did your child have any unusual behaviors or problems prior to age 3? Yes ___ No ___

   Not sure_____ If yes, describe: _____

5. Has your child experienced emotional, physical, or sexual abuse?

   Yes ____ No ____ Not sure _____ If yes, describe: _____

COUNSELING HISTORY

Have your son or daughter previously seen a counselor? ❒ Yes ❒ No

If Yes, where: _____

Approximate Dates of Counseling: _____

For what reason did your son or daughter go to counseling? _____

Does your son or daughter have a previous mental health diagnosis? _____

What did you find **most helpful** in therapy? _____

_____

What did you find **least helpful** in therapy? _____

_____

Has your son or daughter used psychiatric services? Yes____ No____

If yes, who did they see? _____ If yes, was it helpful? N/A____ Yes____ No_____

Has your son or daughter taken medication for a mental health concern? Yes_____ No _____

Name of medication	Dates taken	Was it helpful? (Y/N)

Does your son or daughter have other medical concerns or previous hospitalizations? Y/N _____

If so, please describe. _____

CHEMICAL USE

Do you have any concerns with your son or daughter using alcohol or drugs? (Y/N) _____

If yes, please explain your concern: _____

_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? (Y/N) _____

If yes, please explain your concern: _____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family, son or daughter, at present, or have had a significant effect upon you or your son or daughter in the past. _____

_____

FAMILY HISTORY

Are you aware of any birth trauma your son or daughter experienced from age 0-3? _____

_____

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable. _____

_____ Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)? _____

_____

PARENT'S MARITAL STATUS *(this question refers to the biological parents relationship)*

❒Single ❒Married (legally) ❒Divorced ❒Cohabitating ❒Divorce in process ❒Separated ❒Widowed ___Other

Length of marriage/relationship:_____ If divorced, how old was your child at time of divorce? _____

If divorced, How much time does your child spend with each parent? Mother_____%, Father _____%

(Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.)

Biological Father's Name: _____Birth Date:_____ Age: _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Current Status _____Single, ____Married, ____Divorced, ____Separated, _____Widowed, _____Other

**Please answer if you are no longer with your child's bio-mother OR check here if you are still with bio-mother*_____

Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

Biological Mother's Name: _____Birth Date:_____ Age: _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Current Status _____Single, ____Married, ____Divorced, ____Separated, _____Widowed, _____Other

**Please answer if you are no longer with your child's bio-father OR check here if you are still with bio-father*_____ Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

	fighting		Disagreeing about relatives
	feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a sibling
	Abuse/neglect		Birth of a child
	Inadequate housing/feeling unsafe		Inadequate health insurance
	Job change or job dissatisfaction		Other

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your son or daughter is successful when they try? _____

_____

What personal qualities would you say your son or daughter has? _____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your son or daughter's life? (Please describe) _____

_____

INDIVIDUAL CONCERNS YOU NOTICE REGARDING YOUR SON OR DAUGHTER

SYMPTOM	NONE	MILD	MOD	SEVERE	SYMPTOM	NONE	MILD	MOD	SEVERE
SADNESS					APPETITE CHANGES				
CRYING					WEIGHT CHANGES (UNPLANNED CHANGES)				
SLEEP DISTRUBANCES					PARANOID THOUGHTS				
DISSOCIATION					POOR CONCENTRATION				
HYPERACTIVITY					INDECISIVENESS				
BINGING/PURGING					LOW ENERGY				
DECREASED SEX DRIVE					EXCESSIVE WORRRY				
UNRESOLVED GUILT					LOW SELF WORTH				
IRRITABILITY					ANGER ISSUES				
NAUSEA/ INDIGESTION					SPIRITUAL CONCERNS				
SOCIAL ANXIETY					HALLUCINATIONS				
SELF MUTALATION					RACING THOUGHTS				
CUTTING					RESTLESSNESS				
IMPULSIVITY					DRUG USE				
NIGHTMARES					ALCOHOL USE				
HOPELESSNESS					DECREASED CREATIVITY				
ELEVATED MOOD					EASILY DISTRACTED				
MOOD SWINGS					TRAUMA FLASHBACKS				
DISORGANIZED					WORK ISSUES				
ANOREXIA					PROBLEMS AT HOME				
SOCIAL ISOLATION					PANIC ATTACKS				
PHOBIAS					FEELING ANXIOUS				
OBSESSIVE THOUGHTS					FEELING PANICKY				
GRIEF					SUICIDAL THOUGHTS				
HEADACHES					PAST SUICIDE ATTEMPTS				
LONELINESS					OTHER				

Is there anything else you would like to share: _____

Special Confidentiality Notice for Parents

Your child has the right to private, confidential communication with the doctor, therapist, and treatment team providing his or her care. This means that some of the issues that they discuss will stay between them, and that we will not disclose that information to anyone, including you, unless we have been given permission by your child to do so. We need your child to be open and honest with us in order to understand and treat the full range of issues your child is dealing with, and they may be too scared, angry, or ashamed right now to share those issues with you. We also recognize it is very important for you to know what your child is going through in order to do your job as a parent, which is why we will always encourage your child to be honest with you. We will encourage, prepare and support your child so that they feel safe enough to share those issues with you. According to the federal patient privacy law known as HIPAA, your child will need to give his/her consent for us to disclose:

- All Mental Health records for children age 16 or older.
- All information concerning pregnancy, sexual activity, STD's, and drug/alcohol use or abuse, regardless of the child's age.
- Any information that your child's provider believes, if released, could cause harm to your child or to someone else, or that would significantly harm the treatment relationship with your child.
- You should know that this confidentiality has limits. If there is any threat to your child's life, we have the duty to inform you and help to create a plan for safety.
- In addition, there are situations that we are mandated to report and cannot keep confidential. Those situations include: threats against another person, physical or sexual abuse, neglect, and pregnant women who report using drugs.
- Finally, we recognize how challenging it can be for a parent to raise a child, especially when the child has a mental illness. We know how badly you might want to know everything your child has kept a secret from you, too. We want to be your partner in supporting your child's physical and mental wellbeing, and even when we can't discuss certain details about your child with you, we will always be there for you: guiding you and giving your child the best advice possible to protect him/her and encourage healthy decisions, including being open and honest with you.

INSURANCE INFORMATION FORM

Client's Full Name:_____Birth Date: _____

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: _____ Phone _____

PRIMARY Insurance: _____ MBR ID#:_____ Group#: _____

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

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

Current Medication and Dosage: _____

_____

Insurance Information **Please present ALL insurance cards and Driver's License to the Clinician**

Secondary Insurance: _____ MBR ID _____ Group# _____

Guarantor Name: (Person responsible after insurance): _____

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 a 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.

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 Signature: _____ Date:_____

Clinician Signature:_____ Date: _____

Bay Area Christian Counseling, Inc.

Informed Consent for Treatment

I have reviewed the Bay Area Christian Counseling Patient Information Packet, which Includes information regarding access, fees, Patient Rights and Responsibilities and Privacy Practices. I accept those policies and practices. I understand I may request a copy of these notices if I wish to keep them for my personal records.

Behavior health treatment offers no guarantees. Yet, by working with my therapist, doctor and/or counselor, I will get the support necessary to manage the concerns I bring to Bay Area Christian Counseling. I recognize that I will need to try new ways of dealing with these issues. Together with my therapist, doctor, and/or counselor, I may be asked to develop practices, tasks and/or exercises that I will complete outside of therapy that will complement and enhance the effectiveness of treatment. My openness and willingness to engage in these activities may well have a direct impact on the efficacy of the therapy process.

I agree to fully collaborate with my therapist, doctor, and/or counselor. I agree to ask any questions I have, to clarify my therapeutic goals, and how therapy is addressing them.

I understand that therapy may not continue to be necessary when the concerns I initially had are resolved. I also understand that I can terminate my therapy at any time I wish. I may also ask to transfer to another therapist, doctor, and/or counselor if I feel that my current therapy has been ineffective. I agree to notify my therapist, doctor, and/or counselor of my interest in transferring or intent to end therapy and to schedule a transitional session to discuss the reasons for my decision and the possible risks of premature termination of therapy with that treating clinician prior to transferring or terminating therapy.

I also understand that my therapist, doctor and/or counselor may end my treatment if we do not make progress, or if our relationship becomes too strained to continue working together. If treatment is to be terminated, upon request, my therapist, doctor, and/or counselor will make suggestions to guide me in finding another provider of my choice. I will make every effort to follow these suggestions.

_____ ____/____/____

Patient/ Guardian Signature Date

_____ ____/____/____

Witness Signature Date

Ability to Pay Form

Patient 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**

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

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 60 days, I agree to pay for all services rendered. Any portion of a client balance not paid within 90 days will be charged to the credit card below. 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). That fee 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 $36 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 Signature: _____ Date: _____

Clinician Signature: _____ Date: _____

RELEASE AND/OR OBTAIN INFORMATION FORM

I,_____, AUTHORIZE BAY AREA CHRISTIAN COUNSELING

(Name of Client)

TO RELEASE/OBTAIN INFORMATION CONCERNING MY TREATMENT TO/FROM

_____

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: _____

Clients 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 PIH. 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, Executive Director.

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI

1. Treatment. Our practice may use your PHU 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 your treatment.

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 your appointment.

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.

D. Use and disclosure of your PHI in certain circumstances.

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 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,
   - 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 enforcement official:
    - Regarding a crime victim in certain situation, if we are unable to obtain the person's agreement,
    - Concerning a death, we believe has resulted from a 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).
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 their jobs.
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 following conditions:

    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 the waiver,

    c. The research could not practicably be conducted without access to and use pf PHI

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 the threat.
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 or both, -
   - 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 conduct reviews.

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, Executive Director.
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 a complaint.
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.

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

Client Signature HIPPA Disclosure Date

Clinician Signature Date