Frank Geis, M.A, LMFT, LPC, CSAT, CPTT

1901 North Central Expy. Suite 220, Richardson, TX 75080

(972) 680-8986 X-307 OFFICE (972) 680-9216 FAX

CLIENT INFORMATION AND CONSENT TO TREAT

PATIENT INFORMATION

If services are for a couple or family, please fill out according to whose first name you want on receipts.

Name: _____ Date: _____

Home address: _____ City/State/Zip: _____

Email Address: _____ Date of birth: _____

Phone: Home: _____ Mobile: _____

Single ____ Married ____ Divorced ____ Separated ____ Cohabitating ____ Widowed ____

Gender: Male ___ Female ___ Other ____ Age: _____

Employed by: _____ Occupation: _____

Spouse / Partner: _____ No. of years together: _____

Spouse / Partner's Email: _____ Occupation: _____

Emergency contact name: _____ Contact's #: _____

Relationship to Client: _____

Please Indicate Type (s) of Counseling In Which You Are Interested:

Marital ____ Individual ____ Family ____ Group _____ Neurofeedback _____ Other _____

CHILD OR ADOLESCENT

Name of Client (if child or adolescent):_____ Age: ____ M___ F ____

School name: _____ Grade: _____ Date of Birth: _____

Are the parents of the Client divorced? Yes _____ No _____ **If yes:** According to the divorce decree, who is allowed to seek treatment on Client's behalf**?**

Only Mother _____ Only Father _____ Either Parent _____ Other: _____

Please note a copy of the divorce decree declaring guardianship **MUST be on file before the child can be seen**

Other persons currently living in your home:	**Age**	**Gender**	Relationship to Client
Name: _____	_____	_____	
Name: _____	_____	_____	
Name: _____	_____	_____	

Any children not living in your home: _____ Age: _____

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FINANCIALLY RESPONSIBLE PARTY

Name: _____ Relationship to client: _____

Address: _____ Home Phone: _____

City/State/Zip: _____ Bus. Phone: _____

Employed by: _____ Email: _____

Private Pay: Yes ___ No ____ Using Insurance? Yes ___ No ___

If using insurance you the primary insured? Yes ___ No ____ Name of Primary Insured _____

Name of Insurance Company: _____ D.O.B of Primary Insured: _____

Please provide a copy of your Insurance card and Driver's License if using insurance.

How did you find us? (Please circle and be specific)

FRIEND PSYCHOLOGY TODAY DR. REFERRAL WEB SITE INTERNET SEARCH

OTHER: _____ NAME OF REFERRAL SOURCE: _____

REASON FOR REFERRAL: _____

MEDICAL INFORMATION

Have you previously received any type of mental health services (counselors, therapist, psychiatric services, etc) in the past two years?

□ No

□ Yes, previous therapist/counselor: _____Phone : _____

Issues of concern: _____

Reason for Termination of Counseling: _____

Are you currently taking any prescription medication?

□ No

□ Yes, Please list

Medications:	Prescribed for:	Prescribing Physician:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any inpatient treatment you may have received: _____

_____

Name of primary physician: _____ Phone Number:_____

Name of psychiatrist (if applicable): _____ Phone Number:_____

Any history of depression, anxiety, substance abuse, mental illness, etc. in the family? Yes ____ No _____

If yes, please explain: _____

_____

_____

Is there anything that has not been asked that you may feel or think might be appropriate for your counselor to know? _____

_____

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In your own words, please describe why you are seeking counseling?

_____
_____
_____
_____

GENERAL HEALTH AND MENTAL INFORMATION:

1. How would you rate your current physical health? (please circle)
   Poor _____ Unsatisfactory _____ Satisfactory _____ Good _____ Very Good _____

   Please list any specific health problems you are currently experiencing:
   _____
   _____
2. How would you rate your current sleep habits?

   Poor _____ Unsatisfactory _____ Satisfactory _____ Good _____ Very Good _____

   Please list any specific sleep problems you are currently experiencing:
   _____
3. How many times per week do you generally exercise? _____
4. Please list any difficulties you experience with your appetite or eating patterns?
   _____
5. Are you currently experiencing overwhelming sadness, grief, or depression?
   □ No
   □ Yes, - for approximately how long? _____
6. Are currently experiencing anxiety, panic attacks, or have any phobias?
   □ No
   □ Yes, - when did you begin experiencing this? _____
7. Are you currently experiencing any chronic pain?
   □ No
   □ Yes, - please describe: _____
8. In regards to alcohol I: __ Never Drink __Consume _____ per week
9. In regards to recreational drug use I: __ Have never used drugs __ Currently use
   ___ I used to use but have stop _____ years _____ months age
10. Are you currently in a romantic relationship? □ Yes □ No
    If yes, for how long? _____
11. My Spiritual / Religious preference: _____
12. What significant life changes or stressful events have you experienced recently?
    _____
    _____
    _____
    _____

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PSYCHOSOCIAL STRESSORS

Please indicate any issues that you (the Client) are having difficulty with:

Hopelessness	Hyperactivity	Difficulty relaxing
Fatigue	Sadness	Inferiority Feelings
Helplessness	Panic Attacks	Job Stress
Grief/Loss	Poor Appetite	Thoughts of hurting self
Racing heart	Depression	Thoughts of hurting others
Worthlessness	Weight Issue	Nightmares
Stress	Self-control issues	Anxiety
Divorce/Separation	Anger/frustration	Loss of employment
Lack of enjoyment of life	Marital issues	Phobias
Parenting issues	Isolation/withdrawal	Obsessive thoughts/behaviors
Emotional abuse	Eating disorder	Excessive worry

Have you ever considered or attempted suicide? Yes No

If yes, please explain: _____

_____

ADDITIONAL INFORMATION:

1. Are you currently employed? □ Yes □ No

   If yes, what is your current employment situation? _____

   Do you enjoy your work? Is there anything stressful about your current work?

   _____

   _____

   _____

2. What do you consider to be some of your strengths?

   _____

   _____

   _____

3. What do you consider to be some of your weaknesses?

   _____

   _____

   _____

4. What would you like to accomplish out of your time in counseling?

   _____

   _____

   _____

5. Are you currently involved in any legal proceedings or anticipate being involved in the near future?

   YES ____ NO _____

   If Yes, please provide details: _____

6. If you are represented by an attorney please provide the attorney's name, address and phone number:

   _____

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Consent to Treatment

Please read carefully the following information concerning the professional services and business policies and discuss with your therapist any questions you may have. Your therapist may also go over this consent verbally. Your signature at the end of this document indicates you have read and understand this information, thus providing an agreement for proceeding with treatment.

Qualifications:

Frank Geis, MA, LPC, LMFT, **CSAT**, **CPTT** is a Licensed Professional Counselor (LPC); a Licensed Marriage Family Therapist Associate (LMFT), CSAT – Certified Sexual Addiction Therapist; CPTT – Certified Partner Trauma Therapist; Post Induction (PIT) therapist – family of origin issues developed by Pia Melody, an EMDR practitioner, and an Advance Certified *NeurOptimal* Trainer in Neurofeedback.

Frank Geis, MA, LMFT, LPC, CSAT, CPTT maintains an independent practice at 1901 N Central Expressway, Suite 220, Richardson, Texas 75080 providing a variety of mental health services. Mr. Geis subleases space and contracts for support services from NDCWC, LLC, dba New Directions Counseling & Wellness Center ("the LLC") and is not in a partnership or any other form of business entity with the LLC or with any of the other mental health providers practicing at this location, all of whom maintain their own independent practices.

Orientation: The counselor may be trained in a variety of approaches to therapy, including cognitive-behavioral, family systems and family of origin approaches, psychodynamic and solution-oriented, short-term therapy. Each therapist employs a variety of techniques to assist you in clarifying your goals for change and taking steps in the desired direction. The overall goal in therapy is to assist you in being as healthy as possible physically, mentally, emotionally, relationally, and spiritually. Your therapist believe's all people are created with a need for purpose and meaning, a need for significant connection with others, and a capacity for growth. Thus they are committed to providing quality psychological care to assist you in achieving these goals.

Nature of Psychological Services: The purpose of psychological treatment may include relieving distress; decreasing symptoms of a mental or emotional disorder; improving one's mood, self-esteem, or overall wellbeing; working through trauma or loss; working to improve significant relationships; or learning better coping skills for life's challenges. As such, psychotherapy is not an exact science and it is not like a visit to a medical doctor, but rather requires your active participation in identifying problems and goals and working to make changes. Your therapist will work to create a safe setting in which you feel respected and accepted in order for you to openly discuss issues which may be at times personal and uncomfortable. Your therapist will be sensitive to the pacing and timing of these discussions to maximize a therapeutic result.

Purposes, Goals and Techniques of Therapy: There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by the therapist and to have input into setting the goals of your therapy. As therapy progresses these may change. Initially, the undersigned therapist will gather information and assess and evaluate your condition and needs. This might take several sessions after which the therapist will offer his/her findings, conclusions and treatment recommendations. If both you and the therapist then both agree to go forward with counseling from the counselor, the initial treatment plan including the purposes, goals and techniques of counseling will be agreed to and documented.

Therapy Relationship: Sessions are usually 45-50 minutes on a weekly basis. Less frequent sessions will be scheduled as improvements occur, goals are met, and you near the end of treatment. Feel free to express your preferences for scheduling of sessions, as your needs will likely change over the course of therapy. While psychotherapy often addresses very personal issues, for your work to be therapeutic the relationship between you and your therapist must be a professional relationship rather than a social one. Personal and/or business relationships undermine the effectiveness of therapy. Payment for services rendered is the only remuneration that is expected. Contact with your therapist will be limited to sessions you schedule at our office. Your therapist will not accept friend requests on social networking sites. Emergency phone calls after hours will be handled as follows: if it is life-

threatening, you will be directed to call 911 or go to your nearest emergency room. Crisis management calls will be brief and aimed at stabilizing the situation for processing at your next scheduled appointment. Any phone calls lasting more than 10 minutes will be charged per minute at your regular session rate. For example: if your regular session fee is $100/per a session, a call lasting 15 minutes will be charged $25.00. $100/60 minutes = $1.67. 15 minutes x $1.67 = $25.00. This same pricing structure will be used for email correspondence. For your protection, we advise emails to be limited to dealing with typical office matters such as scheduling or billing questions. Email is not a secure form of communication and your confidentiality cannot be guaranteed. All other matters should be discussed during your session time.

Effects of Therapy: Psychotherapy can have benefits and risks. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. However, we cannot guarantee your specific results. Progress depends on many factors including motivation, effort, and how well you work with your therapist as a team. Additionally, therapy at times involves unpleasant feelings and addressing issues that initially may be difficult, even painful. The changes you make may impact your relationships, your functioning on the job or at home, or your understanding of yourself. Some of these changes may be temporarily distressing. Whenever possible, your therapist will anticipate these risks and discuss them with you throughout the course of therapy. Your therapist is committed to working with you to achieve the best possible results for you.

Patient Rights: Some individuals only need a few sessions to achieve their goals; others may require months or even longer. Your first 1-3 sessions will involve an evaluation of your needs and goals. Your therapist will then offer you some initial impressions of what your work will include and make recommendations regarding a treatment plan. Your active involvement in this plan, along with your opinion of what you need and whether you feel comfortable working with your therapist are crucial to your success in therapy. You have the right to discontinue your professional relationship with your therapist at any time, though it is recommended you schedule a termination session for reaching closure. You also have the right to refuse any recommendations your therapist makes. If your refusal compromises your therapist's ability to render services in an ethical or beneficial manner (e.g. refusal to make a safety contract when feeling suicidal), your therapist may determine to discontinue treatment. In such cases, you will be provided with referrals to another competent mental health professional, if you desire. Our services will be rendered in a professional manner consistent with the legal and ethical standards established by the Texas Behavioral Health Executive Council. If at any time or for any reason you are dissatisfied with our services, please let your therapist know. If you are still unsatisfied, you may report your complaints to the Texas Behavioral Health Executive Council at 1-800-821-3205 or www.bhec.Texas.gov.

NOTICE TO CLIENTS: The Texas Behavioral Health Executive Council investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers, and licensed specialists in school psychology. Although not every complaint against or dispute with a licensee involves professional misconduct, the Executive Council will provide you with information about how to file a complaint. Please call 1-800-821-3205 for more information.

Referrals: Throughout the course of therapy, your therapist may make recommendations concerning treatment, some of which may involve alternative treatment options we do not provide, e.g. hypnotherapy, medication evaluations, inpatient or intensive outpatient treatment, to name a few. If at any time you or your therapist believes a referral is needed, you will be provided recommendations for other providers or programs to assist you. Alternative treatment options and/or adjuncts to therapy may also be discussed at your request (e.g. support groups, community services). You will be responsible for contacting and evaluating those referrals or alternatives.

Fees and Payment:

In order to fully focus on you and allow you to concentrate on your concerns and issues, payment from individuals is made prior to the start of the session. **The fee I charge for a 50-minute session for counseling is $160 per session and $170 per session for marriage counseling if paying by check or cash; and $165 and $175 if paying by credit card.**

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Sessions may be scheduled for more or less than 50 minutes and will be billed in proportion to the hourly rate. Payment is expected at the time services are rendered. I request you keep a credit card authorization form on file for billing purposes. If you wish to pay by personal check or with cash, you may do so but we may still need a credit card number on file to bill for no show or late cancellations. If payment becomes a hardship for you, please discuss this with me so a suitable payment plan can be arranged for you.

Other services for which additional fees may apply include: telephone calls, clinical consultations with other providers that you give consent for your therapist to speak with; preparation of treatment summaries or treatment plans, letters or documents for employment, disability, or legal purposes; and photocopying and/or mailing of medical records to you, to another provider, attorneys, or insurance companies.

For legal proceedings that require your therapist's response, we bill $500 per hour (includes time spent responding to subpoenas, depositions, time spent waiting to testify, driving time to the court, etc.). The court fee will be billed at the stated amount with a **4-hour minimum** charge. Payment is due and is **non-refundable 48 hours in advance**. Any additional time spent on the day of court/deposition appearance will be billed within 24 hours and is expected to be paid in full within 48 hours of the bill being sent. Out-of-pocket expenses associated with travel shall also be billed to you with the same expectation of payment. You are responsible for **ANY legal fees** that your therapist incurs as related to your case or treatment (including, but not limited to, any legal consultation that is sought regarding your case or treatment). Your therapist reserves the right to suspend services if there is an unpaid balance in your account. With regard to litigation, please note that a Licensed Professional Counselor (LPC) and Licensed Marriage and Family Therapist (LMFT) are not considered an expert witness in the courts. LPCs and LMFT's are considered a "witness of fact" in the state of Texas. Any testimony given by LPCs or LMFTs in court will be allowed only as a "witness of fact". **Payment will be expected from you, regardless of whose attorney subpoenas my involvement**. Patient records will not be released without written consent unless court ordered to do so. Please note: a subpoena does not constitute a court order.

Cancellation Policy: I understand that my therapy appointment time is a reservation just for me. If you are unable to keep a scheduled appointment or need to change an appointment, please notify our office as soon as possible. Counseling appointments not kept or cancelled less than 24 hours in advance will be billed for the time scheduled at **a rate of $160**. Insurance does not cover the cost of missed visit fees. It is the client's responsibility to leave notice of cancellation on my voice mail or my email, which will note the day and time you contacted me. Your communication with our office about appointment cancellations allows me to offer that time to other clients who may need to be seen.

Cardholder Name: _____

Type of Card: ☐ **Mastercard** ☐ **Visa** ☐ **Discover**

Account Number: _____ **3 Digit Code**: _____

Expiration Date: _____

Zip Code: _____

Signature: _____ **Date:** _____

I authorize Frank Geis M.A., LPC, LMFT, CSAT to keep my signature on file and charge my credit card account listed below for the following:

1. Balances of charges not paid within 30 days, but not to exceed $300.00.
2. Cancellation fee if an appointment is not cancelled within 24 hours.

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Records and Confidentiality: All records may legally be disposed of five years after the file is closed.

Trust and openness are essential for effective therapy. Our communications over the course of therapy become part of your **protected health information,** recorded in your patient file, which will remain confidential and stored securely. The personnel in our office who may need to access your file for administrative purposes are also bound by confidentiality. When disclosure of your records is required by law, you will be notified. Most of these provisions were described to you in the **notice of privacy practices** that you received with the intake packet.

You should be aware of the following **Exceptions to Confidentiality:**

1. You provide consent to release your records or to share information regarding your treatment.
2. You are at risk of imminent serious harm to yourself or others*;
3. You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person;
4. You disclose sexual misconduct of a physician or therapist;
5. Information is requested by your insurance company pertinent to processing claims for payment;
6. A court order is received to disclose information (e.g. child custody or mental competency cases);
7. You file a complaint with a licensing board or in cases of a malpractice suit; records will be released to the Board and/or legal counsel.

*In the event that you are deemed an imminent danger to yourself or others, your therapist has a professional duty to contact the proper authorities. ***Medical and/or law enforcement officials may be notified with or without your consent.***

Please indicate in the spaces below who you give consent for me to contact in the event of any emergency:

Name	**Phone Number**	**Relationship to Patient**
_____	_____	_____
_____	_____	_____

Couples/Family Therapy: When seeing couples or families, your therapist will treat as confidential (within the limits cited above) information you disclose that you specifically request not be shared with your partner or family member. However, open communication is encouraged between couples and families, and your therapist may reserve the right to terminate treatment if he/she judges a secret to be detrimental to the therapeutic process.
You should be aware that some insurance plans do not cover marital and/or family therapy.

Phone Messages, Fax Transmissions, and Email:

HIPPA regulations and our professional Code of Ethics both require that we keep your Protected Health Information private and secure, and indeed we want to do so. We always prefer to have communication via a phone call. Email and texting are very convenient ways to handle administrative issues, but neither is 100% secure. Some of the potential risks you might encounter if we e-mail or text include:

- Misdelivery of email to an incorrectly typed address.
- Email accounts can be "hacked", giving a 3rd party access to email content and addresses.
- Email providers (i.e. Gmail, Comcast, Yahoo) keep a copy of each email on their servers, where it might be accessible to others.
- Our phone might be visible to others who could see a text message.
- If a phone is stolen the security might be breached, making text messages accessible by others.
- Text messages can be accessed online by the account holder. If you are not the primary account holder this may mean a family member can access your messages.

For these reasons, we will not use email or text to discuss clinical issues (i.e. the important things that need be talk about in session.)
If you are not comfortable with these risks, administrative issues will be managed via phone calls.

I ☐ DO ☐ DO NOT

consent to use electronic communication for administrative matters. If given, consent will expire 2 years after our last appointment. This means that we will not initiate contact via email or text, but that we will briefly reply if you do.

Please initial the following that apply: I also hereby authorize messages may be left for me regarding appointments or returned calls…

____ My home answering machine ____With a family member ____My cell phone ____My work voicemail
____ Text messaging ____ Email

____ I acknowledge that medical records, insurance information, or other information concerning my treatment may be sent by fax transmission when a release of information has been authorized.

____ Emails may be checked only during business hours (not on weekends), and thus should not be used for conveying urgent or highly sensitive information. Be aware that information sent via email is not guaranteed to be secure.

Transfer of Records: In the case of death or incapacity, the therapists in this office have made provision for another mental health provider to take possession of all patient records. In this event, you may contact Frank Geis for information concerning how to access a copy of your record or how to have your record transferred to another mental health professional of your choosing.

Social Media:
Your therapist does not accept friend or contact requests from current or former clients on any social networking sites. Adding clients as friends or contacts on these sites can compromise confidentiality and privacy of both the therapist and the client. It can blur the boundaries of the professional relationship and are not permitted. Any attempt by a client to surreptitiously gain access to the therapist's personal site(s) will be cause for termination of the therapy.

Video or Audio Recordings:
You acknowledge and, by signing this Client Information and Consent to Treatment below, agree that neither you or the undersigned therapist will record any part of your sessions and phone conversations unless you and the therapist mutually agree in writing that the session and phone conversation may be recorded. You further acknowledge that the undersigned therapist objects to you recording any portion of your sessions and phone conversations with out the therapist's written consent.

Defamation:
By signing this Client Information and Consent to Treatment below, you agree that you will not make defamatory comments about the undersigned therapist to others or to post defamatory commentary about the therapist on any website or social media site. In the event that defamatory remarks about the therapist are made by you, or others acting in concert with you, you further consent by signing this intake and consent form below to allowing the therapist to use confidential information necessary to rebut or defend against, or prosecute claims for, the defamation.

Cooperation of Client:
You shall keep the undersigned therapist informed of the location or your residence and current contact information and promptly provide the undersigned therapist with any changes of address, phone number, contact information or business affiliation during the time period which the undersigned therapist's services are provided. You shall comply with all reasonable requests of the undersigned therapist in connection with therapeutic treatment. The undersigned therapist will set boundaries including forms of client interactions and communication. The

undersigned therapist may choose to cease to providing services to you for good cause, including without limitation: your failure to respect boundaries, your refusal to comply with treatment recommendations, the undersigned therapist or staff becomes uncomfortable working with you or your failure to timely pay fees or deposits in accordance with this Client Information and Consent To Treatment, subject to the professional responsibility requirements to which the undersigned therapist is subject. Either the client or therapist may choose to terminate the counseling relationship at any time. If the undersigned therapist terminates the relationship, he or she will provide the client referrals for more appropriate services should this be needed. It is further understood and agreed that upon such termination of services of the undersigned therapist, any of your deposits remaining in the undersigned therapist's account shall be applied to any balance remaining owing to the undersigned therapist for fees and/or expenses and any surplus then remaining shall be refunded to you.

I, voluntarily, agree to receive (or agree for my child to receive) Mental Health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care (or my child's care), treatment, or services, and that I may stop such care, treatment, or services that I receive (or my child receives) through the undersigned therapist at any time. By signing this Client Information and Consent to Treat, I, the undersigned client (or parent), acknowledge that I have read, understood and agreed to comply with and be bound by all the terms, conditions and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. **I understand that, should I require services when my therapist is on vacation, this consent is transferable to the covering professional as designated by my therapist. I have been furnished a copy of this statement**.

Patient Signature: _____ Date: _____

Parent/Legal Guardian: _____ _____ Date: _____
(If patient is under age 18)

Therapist: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed
and how you have access to it.

Protected health information about you is obtained as a record of your contacts or visits for healthcare services. This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

The therapist is required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law.

Your Rights Under the Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

You have the right to receive and we are required to provide you with a copy of this Notice of Privacy Practices -
We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at

that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

You have the right to authorize other use and disclosure - This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to designate a personal representative - This means you may designate a person with the delegated authority to consent to or authorize the use or disclosure of protected health information.

You have the right to inspect and copy your protected health information - This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record. In certain cases we may deny your request.

You have the right to request a restriction of your protected health information - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases, we may deny your request for a restriction.

You may have the right to have us amend your protected health information - This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

How We May Use or Disclose Protected Health Information

Following are examples of use and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For Treatment - We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

For Payment -Your protected health information will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations - We may use or disclose, as needed, your protected health information in order to support the business activities of our practices. This includes, but is not limited to business planning and development, quality assessment and improvement medical review, legal services, and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally, it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

Other Permitted and Required Uses and Disclosures

We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required by Law - We may use or disclose your protected health information to the extent that the law requires the use or disclosure.

For Health Oversight - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Cases of Abuse or Neglect - We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, file disclosure will be made consistent with the requirements of applicable federal and state laws.

For Legal Proceedings - We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Required Uses and Disclosures - Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Manager of your complaint or by calling 1-800-942-5540.

By signing below, you confirm that you have read the above information regarding your Private Healthcare Information.

_____ _____
(Signature of client, or in the case of a minor, their legal guardian) (Date)

_____
(Printed name of client)