Robert N. Karman, Ph.D.

PATIENT REGISTRATION & INSURANCE VERIFICATION

BASIC INFORMATION 1 of 3

Today's Date: _____ **Initial Apt:** **Date:** _____ **and Time:** _____

Patient Name: _____
Last **First** **MI**

Parent/Guardian: _____ **Relationship:** _____

Mailing Address: _____ **City&Zip**_____

Apt Reminder Calls: ☐ **Yes** ☐ **No** **Best Number to Call:** _____

Alternate Phone: _____ **E-mail Adr:** _____

Pt. DOB: _____ **Pt. SSN:** _____ **Marital Status:** **S M D W**

Emergency Contact: _____ **Relationship:** _____

Emergency Contact Phone: _____ **Adr:** _____

PRIMARY INSURANCE

Insurance Company: _____

Insured's Name" _____ **Gender:** ☐ **M** ☐ **F** **DOB:** _____

Patient relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other:** _____

Insured's/Sponsor's Adr: _____

Insured's/Sponsor's SSN: _____

City/State/Zip: _____ **Phone:** _____

Insured's ID No: _____ **Policy Group No:** _____

Insured's Employer/School: _____

Insured's Plan Name: _____

Claim's Adr: _____

Insurance Phone: _____ **FAX:** _____

Robert N. Karman, Ph.D.

PATIENT REGISTRATION & INSURANCE VERIFICATION

BASIC INFORMATION 2 OF 3

Patient Name: _____ Today's Date: _____

☐ Yes ☐ No The patient has a second insurance policy. _____
Initial here

☐ Yes ☐ No Friends or family members have seen or are seeing Dr. Karman:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Referred by: _____ Relationship: _____

Reason(s) for seeking treatment now:

☐ Crisis
☐ Family therapy
☐ Work issues
☐ Employee Evaluation
☐ Special Testing
☐ Need Forms completed:
_____

☐ Individual therapy
☐ Couples' therapy
☐ SSI evaluation
☐ Custody issues
☐ Need consultation on: -
_____

☐ Other: (explain) _____

BENEFIT AND ELIGIBILITY INFORMATION (OFFICE STAFF USE ONLY)

Insurance Co: _____ Spoke with: _____

Authorization #: _____ Start/End Date: _____

# of sessions: _____ Deductible: _____ Deductible met: ☐ Yes ☐ No

COPAY: _____

Parity $_____ # of sessions: _____; Non-parity: _____ # of sessions: _____

Robert N. Karman, Ph.D.

PATIENT REGISTRATION & INSURANCE VERIFICATION

BASIC INFORMATION 3 OF 3

SECONDARY INSURANCE, IF ANY

☐ **Not applicable** ☐ **Yes, second policy information follows:**

Patient Name: _____

Insurance Company: _____

Insured: _____ **Gender:** ☐ **M** ☐ **F** **DOB:** _____

Patient relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other:** _____

Insured Adr: _____

Insured Adr 2: _____

City/State/Zip: _____ **Phone:** _( )_____

Insured ID No: _____ **Policy Group:** _____

Insured's Employer/School: _____

Insured's Plan Name: _____

Claim's Adr: _____ **Phone:** _____

INSURANCE BILLING AUTHORIZATION

Patient Name: _____ DOB: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

I hereby authorize the release of information:

TO AND FROM
Robert N. Karman, Ph.D.
57402 29 Palms Hwy Suite 10
Yucca Valley, CA 92284
760-219-7924

AND

Health Insurance Company: _____

Please read the following declaration then sign and date below where indicated.

I request that payment of authorized medical services furnished to me or my minor child be made by my insurance company, on mine or my minor child's behalf, to the provider of service indicated above. I authorize the medical provider listed above and his agents to release any information concerning my medical care to my insurance company and any of its agents for the sole purpose of determining benefits payable on my medical related charges.

I understand my signature on this form authorizes my insurance company to make payment directly to the provider referenced above and that I am authorizing my provider to release all medical information necessary to adjudicate my medical claims. The patient is responsible for deductibles, coinsurance, in any non-covered services. This policy applies to secondary and subsequent plans as well.

_____ _____
Signature of Patient (Parent/Guardian/Conservator) Date

Relationship to Patient: _____

Office of Robert N. Karman, Ph.D.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

THIS AUTHORIZATION TO RELEASE, TO REQUEST OR TO DISCLOSE INFORMATION IS TO COMPLY WITH THE TERMS OF THE CONFIDENTIALITY OF MEDICAL INFORMATION ACT 1981, SECTION 56 ET SEQ., CA CIVIL CODE.

_____ _____/_____/_____

Patient Name D.O.B

_____

Address City/State/Zip

I hereby authorize the release of information:

☐ To and From ☐ To ☐ From

Robert N. Karman, Ph.D.
57402 29 Palms Hwy. Suite 10
Yucca Valley, CA 92284
(760)418-5997 F: (760)820-1094

Name: _____ Relationship or title: Primary Care Provider

Address: _____ Phone: _____

FAX: _____

For: ☐ Coordination of Care ☐ Disability Evaluation ☐ Other_____

Limits on information disclosure: ☐ None ☐ Limit to _____

I understand that I can receive a copy of this authorization upon my request. This authorization may be removed in writing at any time by the undersigned, and if not earlier revoked, shall terminate on: _____.
(Date, or terms)

_____ _____

Signature of Patient (or: ☐ Parent/ ☐ Guardian/ ☐ Conservator) Date

_____ _____

Robert N. Karman, Ph.D. Date
Psychologist PSY9274

Robert N. Karman, Ph.D.
OFFICE POLICY ON COMMUNICATION AND APPOINTMENTS

For some people making and keeping appointments except for emergency situations is easy. They prefer as we do having standing appointments (same day and time each week or every other week). They keep us up to date on how they can be reached if they change phone numbers. There are enough exceptions to this that our office has formulated policy and procedure for those who cannot work with our routine scheduling and/or maintain a way for us to contact them between appointments.

SCHEDULING AND EMERGENCY MANAGEMENT

We try to schedule appointments at the same time each week or every other week to establish a routine for patients and our office to better manage everyone's time and schedule. But we all know emergencies happen. Cars don't start, tires pick up nails and go flat, a child suddenly gets the flu. Life happens. We simply ask that you call us as-soon-as-possible so we can work around your emergency. If you are ill or have to attend to a sick child and don't have someone to watch them, stay home and call us. We don't want what you or yours have. Just call us as soon as you can.

If your life for a time seems to be a continuous series of such emergencies, and that can happen to anybody, perhaps you need a break from regular appointments to preserve your relationship with us. Return when you are ready. Keeping us posted is all we ask.

FEES FOR MISSED APPOINTMENTS NOT DUE TO AN EMERGENCY

When insurance allows this, we charge a missed appointment fee of $35 based on time when someone from our waiting list could have been scheduled.
Initial: _____

This may seem like a challenge for some because finances are tight but that is all the more reason to have some systematic manner of keeping track of appointments and keeping them. Therapy is not a consultation every two months for a med check. We understand that there are people who feel such relief that they finally made an appointment that actually attending may suddenly lose importance. Therapy may not be for them and discussing this may be important for both patient and therapist to develop a clear understanding of mutual goals.

CONTACT INFORMATION

Robert N. Karman, Ph.D.

OFFICE POLICY ON COMMUNICATION AND APPOINTMENTS

We cannot conduct a practice kind without being able to contact our patients. Our services require us to be able to contact you. Here are a few things that will help us both:

- Keep us updated on changes on how to reach you, phone number(s) and e-mail address(es).
- Keep your cell phone and answering machine/service cleared out. If we call and find your mailbox is full and have no other way to reach you, it limits our ability to serve you well.
- Read your e-mail regularly. It's our best backup way of contacting you.

SELF-MANAGEMENT

There are many ways to keep track of appointments and things you must do. Some use electronic gadgets such as a phone or similar device. Others use a calendar taped to their refrigerator, etc., etc. The main thing we have found important is for you to discover what works for you and stick to that method. Trying to have several ways of personal organization often means having none. Here are some easy to use materials at www.drkarman.com, Dr. Karman's website, if you need some options to explore but whatever you do, keep in mind that your personal organization affects other people as well as yourself and that we expect you to be responsible for keeping appointments and keeping us informed when you can't.

By my signature below I indicate that I agree to abide by the above policies and procedures.

Patient Name: _____
Please print

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____
Robert N. Karman, Ph.D.
Psychologist PSY9274

ROBERT N. KARMAN, PH.D.

OFFICE POLICIES AND FINANCIAL CONTRACT
WITH CONSENT FOR ADULT TREATMENT

Welcome to our office. We want your psychological needs to get the best and most effective treatment possible. A sound relationship between patient and therapist is based in part on a mutual understanding of these general office policies and the fees and financial arrangements involved. Sessions are by appointment only, and we find that setting up a standing appointment time (same day of week and time of day is best for all concerned. After regular office hours, please leave a voicemail to re-schedule or cancel an appointment.

Treatment Philosophy

Outpatient psychotherapy consists of face-to-face contacts between a licensed professional and patient, and may include individual, group, family, short or long term therapy, crisis intervention or medication consultation.

If your contract is with managed care, therapy will be brief and problem focused. You will be expected to participate in both setting and achieving treatment goals. A Case Manager will oversee your number of sessions and will request information about your therapy. You will be asked to sign a release of confidential information for that purpose.

Regular attendance is necessary to receive the maximum benefit possible from treatment. Appointments are generally 45 minutes long and are reserved for you in our calendar. It is customary and reasonable to require that you give a 24-hour notice for a cancellation of a scheduled appointment. Managed care and insurance companies cannot be billed for these cancellation fees. A pattern of failure to keep appointments or failure to give 24-hour notice to cancel may be terms for the insurance or managed care company to disallow treatment. (Please initial_____).

Financial Contract, Deductibles, and Co-payments

You are responsible for obtaining prior authorization from your insurance or managed care company prior to treatment. If this office accepts your insurance or we are contracted with your care company, you are responsible for the co-payment amount and the deductible as set by your benefit plan.

Co-payment amounts are set by your benefit plan. These payments are due and payable at the beginning of each appointment. If you desire services not provided

by your managed care company or benefits beyond your benefit contract, you will need to sign a separate written contract with this office if we agree to provide your request. (Please initial_____).

Telephone Calls

If there should occur a time where essential concerns must be discussed on the telephone, the Provider charges at the same rate as the contracted rate above, based on the amount of time spent on the telephone. These charges will be your personal expense if they cannot be billed to your insurance company. (Please initial_____).

Limits Of Confidentiality

All information and records obtained during the course of treatment shall remain confidential and will not be released without a signed written consent. The legal exceptions to your confidentiality are as follows:

1. If a therapist believes that a patient intends to eminently commit serious bodily harm to another identifiable person or persons, it is the therapist's duty to warn the person or persons of intended harm as well as the authorities (Tarassoff vs. Regents of University of Cal., 1976).
2. If a therapist believes that a patient intends to eminently commit serious bodily harm to himself, it is the therapist's duty to take necessary action to protect the individual, which may include notifying authorities (Johnson v. County of Los Angeles, 1983).
3. If a patient becomes involved in certain kinds of very important court cases, a judge may subpoena records and/or testimony. This is rare, but the therapist's ability to shield confidentiality in these cases may be compromised and varies from case-to-case.
4. If a therapist suspects that a child, elder, or dependent adult either is currently being abused, or has been abused in the past (where there is a risk of re-offense), and the authorities don't already know about it, it is the therapist's duty to inform the authorities (Welfare & Institution Codes, Penal Codes Section 11165, 11166 and others).

ROBERT N. KARMAN, PH.D.

OFFICE POLICIES AND FINANCIAL CONTRACT
WITH CONSENT FOR ADULT TREATMENT

Releases of Information

Certain insurance companies (Medicare) and managed care companies ask us to get a release to the primary care physician to coordinate care. You may refuse this request or you can allow it. You will be asked if you wish to sign a release of confidential information form.

If you are electing to use your insurance or managed care benefits, you will be required to sign a release of confidential information to your benefit plan so as to process claims for certification, case management, quality assurance, benefit administration and other purposes such as utilization. If you do not want such information to be shared with your benefit plan, you may pay privately without using your insurance company.

Consent for Treatment

I authorize and consent to treatment, which may include various psychological assessment techniques, psychological exams, diagnostic procedures, and psychotherapeutic services. I understand that while psychotherapy is intended to be helpful, no guarantees as to outcome can be made. The psychotherapeutic process can cause a person to experience unpleasant emotions, feelings and reactions such as anxiety, sadness, and anger. These responses are normal, if they should occur, and I agree to work through these responses with my therapist.

I accept and consent to the office policies, financial arrangements, as well as the terms of each of the foregoing paragraphs of this contract.

Patient Name: _____
Please print

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____
Robert N. Karman, Ph.D.
Psychologist PSY9274

Scheduling

We keep things simple. We find "standing appointments" -- on the same day at the same time each week - work best for all. We also strongly want you to have a system to keep track of all of your appointments. Do not trust your memory, especially if you are a busy person.

Policy Regarding Missed and Cancelled Appointments

I understand and agree that when I need to cancel an appointment, I will call the office and either inform them directly or leave a message at least twenty-four hours prior to the scheduled appointment.

If I should fail to cancel twenty-four hours or more prior to the scheduled appointment, I agree that is to be considered a missed appointment. If I miss two appointments without notifying the office at least 24 hours in advance of the appointment time, I understand and agree that this office will terminate my treatment.

For our part, if things come up, we try to contact you. If Dr. Karman is ill or has an emergency situation and can't come to the office, we call as soon as we know. If there may be upcoming jury duty or similar "iffy" situation, we alert you. And we ask that you call in to see if Dr. Karman will be here before you make the trip to the office. That is our courtesy to you, for we value your time as we do our own time.

In return, we ask that you tell us your status when you are ill or have an emergency or other unavoidable situation that prevents you from attending a scheduled therapy appointment as soon as possible. While we have a 24 hour notice policy, even a cancellation call the day of the appointment can help us manage our time better.

If you miss an appointment, please still call us and tell us your status so we can plan better and accommodate those wanting treatment from our waiting list and patients with emergencies. Now if you are ill, e.g. have the flu, please stay home,

and don't spread it around. But call us; let us know your status and confirm your next appointment if you plan to continue therapy.

We are a service business. We seek to keep our work schedule as full as possible. Some people start and attend most every therapy session. Other people are more challenged to attend regularly.

A ***pattern of missed appointments*** without a call strongly suggests to us that you are not as interested in therapy as we are in providing it. We may remove you from our schedule. You can call later to make another appointment, but we cannot guarantee a time will be available to you. It depends on our waiting list and demand for our services.

Sometimes there are periods of time when circumstances interfere with treatment. Please try to be realistic about that. You can take a break from therapy if needed. You can always resume later. Having a long series of cancellations with us isn't the best choice for either of us.

Forms

If you have a form or especially a short letter to be written, tell Dr. Karman about it at the beginning of your session. If you wait until the end, it may not get done until your next appointment. There may be release of information form(s) to be completed and signed. We may need the address or fax number of a doctor or attorney. Dr. Karman may also need to interview you for specific details.

Social Security Disability Evaluations

Therapy does not necessarily include a formal, complex evaluation.

Dr. Karman **does not perform Social Security Disability Evaluations.** Your attorney will be able to refer you to the appropriate professional.

Child Custody Evaluations

We provide treatment for adults, teens and children, but do not perform child custody evaluations, which is actually forensic work. Dr. Karman does not perform those specialized (and expensive) child custody evaluations covered under the so-called 730 Law in California. That law says comprehensive evaluations of

all parties including both parents shall be included in formulating an ***appropriate*** opinion(s) on child custody. That requires someone with full 730 training as well as ***certification*** as a 730 Evaluator. Simply put, we follow the law. Dr. Karman does not formulate opinions contrary to the requirements of 730 law, no matter what you, your attorney, or even a judge requests. He doesn't guess or evaluate people he has not seen.

Policy Regarding Missed and Cancelled Appointments

I understand and agree that when I need to cancel an appointment, I will call the office and either inform them directly or leave a message at least twenty-four hours prior to the scheduled appointment.

If I should fail to cancel twenty-four hours or more prior to the scheduled appointment, I agree that is to be considered a missed appointment. If I miss two appointments without notifying the office at least 24 hours in advance of the appointment time, I understand and agree that this office will terminate my treatment.

Patient Name: _____
Please print

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____
Robert N. Karman, Ph.D.
Psychologist PSY9274

ROBERT N. KARMAN, PH.D.

ADULT LIFE HISTORY QUESTIONNAIRE – PART 1

Thank you in advance for completing this completely and accurately.

Patient Name: _____
(Please print)

Patient Signature: _____

Date: _____

Person Completing This Form: _____
Please print.

Relationship to Patient: Self Other: _____

Signature: _____

ROBERT N. KARMAN, PH.D.

ADULT LIFE HISTORY QUESTIONNAIRE – PART 1

WHY NOW?

Briefly describe why you are seeking treatment today. Please include the emotional, social, and relational factors with a brief history.

_____

_____

_____

_____

_____

What single ***specific event*** made you seek consultation ***today*** as opposed to an earlier time?

_____

_____

_____

_____

Who referred you? _____

Check what applies:	Issue	Explanation
	Not Applicable	
	Court Mandated	
	Criminal or Family	
	Work related	
	Disability	
	Other, explain:	

ADULT LIFE HISTORY QUESTIONNAIRE – PART 1

SELF-ASSESSMENT QUESTIONS

What would you like to see change in your life through treatment?

_____

_____

_____

_____

_____

1. I am a reader and would work on assigned homework:

   Yes, I would definitely read and work on homework everyday.

   Maybe, depends on my time and interest in the specifics.

   I'm not a reader.

   I'm not interested.

   Other: _____

2. I need reminders of my appointments:

   No, I keep a detailed calendar that organizes my schedule.

   Yes, a call the day before would be good.

   Yes, but an e-mail would be better than a call.

   Other: _____

SELF-ASSESSMENT QUESTIONS (Continued)

3. How long do you believe treatment will require for you to reach your goals (Check one):

   Short term: a few sessions

   Medium term: a couple months

   Longer term: more than a couple months

4. How much Internet and other research have you done on your issues? (check what as many as apply to you):

   None

   Some

   Lots

   I don't know how

   I'd like to learn how

5. What are the sources of stress in your life. Put a 1 in the square to the left of the area of greatest stress, a 2 by next most stressful area, etc. Just rank the areas that bother you:

	… Primary Support Group
	… Social Environment
	… Educational Problems
	… Occupational Problems
	… Housing Problems
	… Economic Problems
	… Legal Problems
	… Environmental Problems

ROBERT N. KARMAN, PH.D.

ADULT SYMPTOM CHECKLIST

Is this evaluation based on a time when you ☐ are on medication; ☐ are not on medication; ☐ not sure?

Name: _____ Age: ___ DOB: _____

Date: _____ Signature: _____

Please rate the ***highest severity*** of each symptom listed below during the past two months by putting an X in the box in the Severity column as follows: **0=None 1=Mild 2=Moderate 3=Severe 4=Profound**									
		Severity					Duration		
	Symptom Description	0	1	2	3	4	6 mo. or less	More than 6 mo.	
1.	DEPRESSED/SAD MOOD								
2.	LOSS OF INTEREST/PLEASURE IN THINGS								
3.	APPETITE CHANGE - INCREASE OR								
4.	WEIGHT GAIN								
5.	WEIGHT LOSS								
6.	INSOMNIA. How many hrs./night do you sleep?___								
7.	SLEEPING TOO MUCH Hrs/night? ____								
8.	REPEATEDLY STOPPED BREATH-G DURING SLEEP								
9.	FATIGUE, NO ENERGY								
10.	FEELINGS OF GUILT OR WORTHLESSNESS								
11.	POOR CONCENTRATION								
12.	THOTS OF DEATH WITHOUT INTENT TO ACT								
13.	PESSIMISTIC THINKING								
14.	CRYING SPELLS								
15.	SEXUAL PROBLEMS								
16.	LACK OF FEELINGS								
17.	NIGHTMARES								
18.	FLASHBACKS								
19.	REPEATED THOUGHTS OF PAST TRAUMAS								
20.	INTENSE REACTION/REMINDERS OF PAST								
21.	AVOID THINKING OF PAST TRAUMA(S)								
22.	NERVOUS, ON GUARD								
23.	CONTINUOUS ANXIETY								
24.	IRRITABILITY, ANGER								
25.	EXCESS DIETING, VOMITING								
26.	OFTEN MISS OR ARE LATE TO WORK								
27.	ALCOHOL OR DRUG ABUSE PROBLEM								
28.	SOCIAL LIFE PROBLEMS INCLUDING								
29.	HOME LIFE PROBLEMS								
39.	PROBLEMS WITH CHILD								

ROBERT N. KARMAN, PH.D.

ADULT SYMPTOM CHECKLIST

Continue, rating the ***highest severity*** of each symptom listed below during the past two months by putting an X in the box in the Severity column as follows:
0=None 1=Mild 2=Moderate 3=Severe 4=Profound

		Severity					Duration	
	Symptom Description	0	1	2	3	4	6 mo. or less	More than 6 mo.
40.	CONFLICTS WITH SPOUSE/SIGNIFICANT							
41.	CONFLICTS WITH OTHER PEOPLE							
42.	WORK PROBLEM							
43.	PANIC ATTACKS. How often? _____							
44.	OTHER UNEXPECTED SPELLS OR ATTACKS							
45.	FEAR OF LEAVING HOME							
46.	FEAR OF CROWDS							
47.	FEAR OF PUBLIC PLACES							
48.	FEAR OF HUMILIATION IN BEING SEEN							
49.	OTHER SOCIAL PROBLEMS							
50.	EXCESS WORRY ABOUT 2 OR MORE ISSUES							
51.	EXCESS WORRY FOR SEVERAL MONTHS OR							
52.	MUSCLE TENSION							
53.	REPETITIVE COUNTING, CHECKING,							
54.	DISTRESSING THOTS YOU CAN'T STOP							
55.	OTHER FEARS AND PHOBIAS							
56.	SHORT ATTENTION SPAN							
57.	EASILY DISTRACTED							
58.	TROUBLE FINISHING PROJECTS							
59.	DIFFICULTY OR INABILITY TO ORGANIZE							
60.	FORGETTING APPOINTMENTS, ETC.							
61	CONSTANT INNER RESTLESSNESS							
62.	FRUSTRATED CAREER GOALS							
63.	OTHER MEMORY PROBLEMS							
64.	CONFUSION							
65.	BELIEFS THAT SEEM STRANGE TO OTHERS							
66.	CHRONIC PAIN							
67.	SEVERE HEADACHES							
68.	STOMACH PROBLEMS							
69.	HEART PALPITATIONS							
70.	SHORTNESS OF BREATH							
71.	NUMBNESS OR TINGLING							
72	DIZZINESS							
73	BODY WEAKNESS							
74.	BLACKOUTS							

ROBERT N. KARMAN, PH.D.

ADULT SYMPTOM CHECKLIST

This is a bit different: now please rate the ***highest severity*** of the following symptoms that you have ***ever*** experienced in your lifetime, not just during the past two months, by using the same severity scale as before. Place an X in the Severity column. **0=None 1=Mild 2=Moderate 3=Severe 4=Profound**							Your best estimate of last time occurred:	
		Severity						
	Symptom Description	0	1	2	3	4		
75.	WIDE DAILY MOOD SWINGS							Do these tend to occur together? ☐ Yes ☐ No ☐ Some-times
76.	NEEDED LESS SLEEP, YET NOT TIRED FOR							
77.	HIGH ENERGY FOR DAYS							
78.	EXTRA TALKATIVE FOR DAYS							
79.	RACING THOUGHTS FOR DAYS							
80.	COMPULSIVE SPENDING							
81.	HEARING THINGS WHEN NOTHING THERE							
82.	SEEING THINGS THAT ARE NOT THERE							
83.	THOUGHTS OF HOMICIDE When, how often?							
84.	THOUGHTS OF SUICIDE When, how often?							
85.	SUICIDAL ATTEMPT(S) When and how?							

Comments:

HIPAA PRIVACY NOTICE AND ADVANCE DIRECTIVES

By my signature below I indicate that I have received a copy of the HIPAA authorization, and information about advance directives.

Patient Name (printed) _____

Signature:_____ _____
Date

Relationship to patient:

☐ Self

☐ Parent

☐ Other: _____
Please specify

Extra copies of the HIPAA handout are available in the literature rack in our waiting room. Feel free to take one if needed.

HIPPAA NOTICE OF PRIVACY PRACTICES

Date of Last Revision: 05/10/07
Effective Date: Immediately

This Information is made available to all patients…

THIS NOTICE DESCRIBES HOW BEHAVIORAL HEALTH/MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE APPLIES TO ALL THE RECORDS OF YOUR CARE GENERATED BY THE PRACTICE, WHETHER MADE BY THE PRACTICE OR AN ASSOCIATED FACILITY.

This notice describes our Practice's policies, which extend to:

- Any health care professional authorized to enter information into your chart (including all behavioral health care professionals, RNs, etc.);

- All areas of the Practice (front desk, administration, billing and collection, etc.
- All employees, staff and other personnel that work for or with our Practice;
- Our business associates (including billing services).
- Behavioral health hospitals, and so on.

The Practice provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR THOUGHTS ABOUT YOUR PROTECTED HEALTH INFORMATION

We understand that your behavioral health/medical information is personal to you, and we are committed to protecting the information about you. As your behavioral health professional, we create paper and electronic professional records about your behavioral/physical health, our care for you, and the services and/or items we provide to you. We need this record to provide for your care and to comply with certain legal requirements.

We are required by law to make sure that the protected health information about you is kept private, provide you with a Notice of our Privacy Practices and your legal rights with respect to

protected health information about you, and follow the conditions of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE BEHAVIORAL HEALTH/MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose protected health information that we have and share with others. Each category of uses or disclosure provides a general explanation and some examples of uses. Not every use or disclosure in a category is either listed or actually in place.
The explanation is provided for your general information only.

1) Behavioral Health/Medical Treatment. We use previously given behavioral health/medical information about you to provide you with current or prospective behavioral health treatment or services. Different employees within the Practice also may share information about you including your record(s), prescriptions, and requests of lab work history, treatment, and diagnosis. We may also discuss your behavioral health information with you to recommend possible treatment options. We also may disclose information about you to people outside the Practice who may be involved in your behavioral/medical care after you leave the Practice; this may include your family members, friends, or other personal representatives, **but only if** authorized by you or by a legal mandate (a guardian or other person who has been named to handle your medical decisions, should you become incompetent).

2) Payment. We may use and disclose behavioral health/medical information about you for services and procedures so they may be billed and collected from you, an insurance company, or any other third party. For example, we may need to give your health care information, about treatment you received at the Practice, to obtain payment or reimbursement for the care. We may also tell your health plan about treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

3.) Health Care Operations. Within our practice, we may use and disclose behavioral health/medical Information about you so that we can run our Practice more efficiently and make sure that all of our patients receive quality care. These uses may include reviewing our treatment and services to evaluate the performance of our staff, deciding what additional services to offer and where, deciding what services are not needed, and whether certain new treatments are effective. For both of the following, we will remove information that identifies you from the set of information so others

may use it to study health care and health care delivery without learning who the specific patients are. In this non-identifying way, we may also disclose information to doctors, nurses, technicians, mental health/medical students, and other personnel for review and learning purposes.

4) Disclosure. We may also use or disclose information about you for internal or external utilization review and/or quality assurance to auditors to verify our records, to billing companies to aid us in this process and the like. We shall endeavor, at all times when business associates are used, to advise them of their continued obligation to maintain the privacy of your behavioral health/medical records. We expect then to keep your information in strict confidence.

5) Appointment and Patient Reminders. We may ask that you sign in writing at the Receptionist's Desk or waiting area, a "Sign In" log on the day of your appointment with the Practice. We may use and disclose behavioral health/medical information to contact you as a reminder that you have an appointment for medical care with the practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, e-mail, or otherwise and may involve the leaving of an e-mail, a message on an answering machine, or otherwise which could (potentially) be received or intercepted by others. You have the right, detailed on the next page, to let us know if you prefer some specific form of this communication.

6) Emergency Situations. In addition, we may disclose behavioral health/medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status and location.

Other Uses Of Behavioral Health/Medical Information

Other uses and disclosures of behavioral Health/Medical information not covered by this notice or the laws that apply to us will be made only with your written permission, unless those uses can be very reasonably inferred from the intended uses above. If you have provides us with your permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke our permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Patient Rights

THIS SECTION DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THIS PRACTICE REGARDING THE USE AND DISCLOSURE OF YOUR BEHAVIORAL HEALTH/MEDICAL INFORMATION.

You have the following rights regarding Behavioral Health/Medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy behavioral health/medical information that may be used to make decisions about your care. This includes your own billing records, **but does not include psychotherapy notes.** Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

To inspect and copy your behavioral health/medical record, you must submit your request in writing to our Compliance Officer. Ask the front desk person for the name of the Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies (tapes, disks, etc.) associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to behavioral/medical information, you may request that our Compliance Committee review the denial. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome and recommendations from that review.

Right to Amend. If you feel that the behavioral health/medical information we have about you (**not including psychotherapy notes**), in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the Practice maintains your record.

To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the behavioral health/medical information kept by or for the Practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is inaccurate and incomplete.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures. This is a list of the disclosures we may have made of behavioral health/medical information about you to others.

To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) years back and may not include dates before Aril 14, 2003 (or the actual implementation date of the HIPAA Privacy Regulations). Your request should indicate in what form you want the list (for example, on paper, electronically). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. In general, your information will not be released to anyone except as outlined in this document. However, you have the right to request a restriction or limitation on the behavioral/medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the behavioral health/medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or friend). For example, you could ask that we not use or disclose information about a particular treatment you received.

We may not be able to comply with your request, if the information is exempted from the consent requirement or we are otherwise required to disclose the information by law.

To request restrictions, you must make your request in writing. In your request, you indicate:

- what information you want to limit;
- whether you want to limit our use, disclosure or both; and
- to whom you want the limits to apply, (e.g., disclosure to your parents, spouse, etc.)

Right to Request Confidential Communications. You have the right to request that we communicate with you about behavioral health/medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail or e-mail, or the like.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish us to contact you.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes regarding medications, if you are taking any, efficiency of treatment protocols and the like. All research projects are subject to an approval process, which evaluates a proposed research project and its use of behavioral health/medical information. Before we use or disclose information for research, the project will have been approved through the research approval process. We will obtain a written Authorization from you before using or disclosing your individually identifiable health information. Otherwise we will make the information non-identifiable to a specific patient. If the information has been sufficiently de-identified, an authorization for the use or disclosure in not required.

Required by Law. We will disclose behavioral health/medical information about you when required to do so by federal, state, or local law. Psychotherapy notes are especially guarded, and are considered confidential in most cases.

To Avert a Serious Threat to Health or Safety. We may use and disclose behavioral health/medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Workers' Compensation. We may release behavioral health/medical information about you for workers' compensation or similar programs, if you are claiming a behavioral health injury and we are ordered to do so by legal authority. Workers' compensation programs provide benefits for work-related injuries or illness.

Public health Risks. Law or public policy may require us to disclose behavioral health/medical information about you for public health activities. These activities generally include the need to report births and deaths; or to notify the appropriate government authority if we believe a child, elder, or dependent adult has been the victim of abuse or neglect. We will only make this disclosure if you agree or when required or authorized by law.

Investigation and Government Activities. We may disclose behavioral health/medical information to a local, state or federal agency for activities authorized by laws. These oversight activities include, for example, audits, investigation, inspections, and licensure. These activities are necessary for the payor, the government and other regulatory agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or legal dispute, we may disclose medical information about you in response to a judge's order. This is particularly true if you make your behavioral health an issue in the case. Otherwise, judges do not order the violation of the confidentiality of behavioral health records lightly. They only do so if they consider the information critical for a highly important matter. We may also use your information to defend ourselves or any member of our Practice in any actual or threatened legal action.

Law Enforcement. We may release behavioral health/medical information if asked to do so by a law enforcement official under the following circumstances:

- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Practice; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release behavioral Health/Medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release behavioral health/medical information about patients of the practice to funeral directors as necessary to carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release behavioral/medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for behavioral health/medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the Practice. The notice will contain on the first page, in the top right-hand corner, the date of last revision and effective date. In addition, each time you visit the Practice for treatment or health care services you may request a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact or office manager, who will direct you on how to file an office complaint. All complaints must be submitted in writing, and all complaints shall be investigated, without repercussion to you.

The Office Manager can be reached at this number: 760 418- 5997

You will not be penalized for filing a complaint.