Susan Benaron, MA, LMFT
118 Nevada Arroyo Grande, Cal. 93420
805-270-3558 phone 805-481-1801 fax

INTAKE FORM FOR PSYCHOTHERAPEUTIC SERVICES

Identifying Information

Name: ______________________________ Sex: ___________

Birth date: ________________ Age: ________

Social Security #: ___________________________________

Driver License #: ______________________________

Home telephone: ( ) _________ - ______________ Is it okay to call you there? Yes / No

Leave messages? Yes / No

Preferred contact number: ( ) _________ - ______________

Other contact umber(s):____________________________

Residence address (including zip code):

____

____

Is it okay if we send mail there? Yes / No

If not, what is your mailing address (including zip code)?

____

____

e-mail address: ____

Is it okay if we send mail there? Yes / No

Occupation: ____

Work telephone: ( ) _________ - ______________

Is it okay to call you there? Yes / No Leave messages? Yes / No

How did you hear of Family Relational Therapy or The Play Therapy Cottage?

____

May we thank him/her for referring you? (Please initial your response) Yes ________ No ________

Please provide the name of someone that we may contact in the event of an emergency concerning you.

Name____________________________________ Relationship_______________________
Telephone__________________________

Physical History

Date of your last physical examination: ____________________

Do you have any serious medical conditions? Yes / No

If yes, what?

____

Have you ever had a serious head injury? Yes / No

Have you ever had a stroke, aneurism, or other neurological insult? Yes / No

What medications do you take regularly?

____

Who is your current primary care physician?

____

Social History

Birth place: ___________________________________ Number of siblings: _______________

Highest grade or degree completed in school: ________________

How did you do in school? _______________________

Have you ever been diagnosed with or suspected of having a learning difficulty or other developmental difficulty? Yes / No

If yes, what?

____

Number of times you have been in a committed partnership: __________

Current marital / partnership status: ___________________

If in a committed relationship, for how long? ___________________

Number of children you have: _________ Children's ages: ________________________

Client Name: ____ **Date:** _______/_______/____________

Mental Health History

Have you ever suffered from a mental health concern before now? Yes / No

If yes, what type of problem?

____

Have you ever sought treatment from a mental health care professional before now? Yes / No

If yes, from whom?

____

When and for what?

____

Do you consider the treatment successful? Yes / No

Are you **currently** receiving treatment from another mental health care professional? Yes / No

Have you ever been harmed (e.g., sexually abused) by a mental health care provider? Yes / No

Have you ever filed a complaint or lawsuit against a mental health care provider? Yes / No

Have you ever taken medication for a mental health concern (e.g., depression, anxiety, etc.)? Yes / No

If so, when? ____

If so, what medication(s) and dosage?

____

Alcohol and Drug Use

Have you ever used alcohol or any other non-prescription drug? Yes / No

If yes, do you currently use alcohol or other non-prescription drugs? Yes / No

How often do you use alcohol or other non-prescription drugs?

____

When you use alcohol or other drugs, how much do you consume?

____

Has your alcohol or drug use ever resulted in any problems? Yes / No

Sexual Abuse History

Were you ever sexually abused / assaulted? Yes / No

If so, when?

____

By whom?

____

Did you receive any treatment to help you deal with the experience? Yes / No

Violence and Suicide Risk

Have you ever been in a physical fight with anyone? Yes / No

If you are older than 25 years, have you been in a physical fight since the age of 25? Yes / No

If yes, have you ever used a weapon (e.g., firearm, knife, baseball bat, broken bottle, etc.) in a fight? Yes / No

If yes, have you ever injured another person in a physical fight? Yes / No

Have you ever seriously considered suicide? Yes / No

If yes, are you seriously considering suicide now? Yes / No

If yes, have you ever attempted suicide? Yes / No

If yes, how many times? _____________

If yes, by what means? ____

Client Name: ____________________________________ **Date:** ______/______/_______

Please explain why you believe need therapy. Briefly describe the problem or your chief complaints. Please explain why you have chosen to seek therapy now, opposed to any other time in the past?

____

____

____

____

____

____

Please describe what you would like to see happen as a result of receiving therapy:

____

____

____

____

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INFORMED CONSENT FOR TREATMENT / EVALUATION BY SUSAN BENARON, MA, LMFT

Following is information that might be relevant to your decision to receive psychotherapeutic treatment / evaluation.

INDEPENDENT PRACTITIONERS: As you know, your therapist works with one or more other independent mental health professionals under the names of Family Relational Therapy and The Play Therapy Cottage. The therapists form a group of independently practicing professionals who share certain expenses and administrative functions. While the members of the group share a name and office space, your therapist is completely independent in providing you with clinical services and is solely responsible for those services. Your therapist's records are maintained separate from the records of the other therapists. Except for an emergency situation described below involving the long-term incapacitation of your therapist, no other therapist will have access to your records without your specific, written permission.

GENERAL INFORMATION: There might be alternative treatment approaches available for your condition. You are free to discuss those options with your therapist at any time. You may also seek consultation with another professional about possible treatment options.

Psychotherapy, while intended to heal, carries some risks. For example, at times while receiving treatment a client might experience a temporary worsening of symptoms due to focus on emotionally painful material. If you become concerned that your symptoms are worsening or that your treatment might be causing some negative side effect, please address your concerns with your therapist.

Many people find psychotherapy beneficial for a variety of problems. However, because many factors can influence treatment outcome, we are not able to guarantee that you will achieve all of your desired goals with treatment. If you have questions about the potential benefits of treatment for your situation, please discuss those questions with your therapist. If during the course of treatment you become concerned that you are not benefiting from treatment, please discuss your concerns with your therapist.

You are free to discontinue treatment at any time. It is important that you understand that premature termination from therapy might result in failure to achieve desired treatment goals. You are encouraged to discuss the option of termination and its foreseeable implications given the specifics of your situation with your therapist should you wish to consider it.

LIMITS TO CONFIDENTIALITY: Information you provide during treatment or evaluation is confidential and may not be disclosed without your permission except under specific circumstances, as permitted or required by law.

Disclosure is permitted by law to another clinician, physician, or assisting professional for the purposes of diagnosis or treatment of your case.

Disclosure is required by law under the following circumstances:

1) where there is reasonable suspicion of child abuse;
2) where there is reasonable suspicion of dependent adult or elder abuse;
3) if you communicate to the therapist that you seriously plan to harm another person physically.

Disclosure may be permitted when there is reasonable suspicion that a client presents a danger of violence to himself or herself, or to the person or property of another, and that disclosure of confidential information might prevent the threatened danger.

A court may require disclosure of confidential information in a legal proceeding where your condition or treatment is a relevant concern.

Finally, requests for treatment authorizations and submission of a bill to an insurance company or other third party payor for reimbursement often involves disclosure of information about your condition, symptoms, treatment, or progress. Sometimes an insurance company will require copies of session notes to authorize continuing treatment or process a claim for services rendered. If you request that we bill your insurance company or other third party payor, that request will constitute consent to release the information necessary to obtain treatment authorization and or to process the claim. We will release only the information or materials that are appropriate and necessary for the purpose.

___________ **Please initial here and continue on PAGE 5.**

INFORMED CONSENT FOR TREATMENT / EVALUATION
BY SUSAN BENARON, M.A., LMFT

(CONTINUED FROM PAGE 4)

CONFIDENTIALITY IN GROUP/FAMILY/COUPLES TREATMENT: Confidentiality is important to the therapeutic process because it provides the basis for trust and honesty. If you participate in a therapy modality that includes other clients, you are responsible for maintaining the confidentiality of what others disclose during the course of treatment. They have that same responsibility to you. Persons who violate the confidentiality of others in group therapy may be asked to discontinue the group treatment and may receive a recommendation for another treatment modality.

SECRETS POLICY: The therapists believe that some secrets, when held from a family, spouse, partner, and/or specific others, can be destructive to the relationships of the individuals involved, including the holder of the secret. When working with families, couples, or other groups, the therapist reserves the right, when asked to maintain a secret, to work toward its disclosure when disclosure has been determined by the therapist to be in the best interests of the parties involved.

CONSULTATION WITH OTHER PROFESSIONALS: At times your therapist may deem it appropriate to consult briefly with another professional about your case. Brief consultations are ethically appropriate to ensure that you are being provided the best possible treatment. If your therapist believes it is appropriate to consult with someone else regarding your case, she will not use your name or any unique identifying information unless you give permission to do so. If extensive consultation that would involve disclosure of your name or other unique identifying information is required, your therapist will seek your written consent to do that.

EMERGENCY CONTACT: If you are experiencing a life-threatening clinical emergency, please call the Helpline at (805) 928-5818, dial 911 or go to your nearest emergency room immediately.

In the event of the unexpected death or long-term / permanent incapacitation of your therapist, you will be contacted by another clinician to arrange continued care. Susan Benaron's clients will be contacted by another Family Relational Therapist.

RECORD KEEPING AND ACCESS TO RECORDS: While your case is active, our records our maintained in paper format and stored in a locked closet. Upon closure of the case, the records may be electronically archived. As a client, you have the right to request access to your records. Ethical standards require that we consider the impact that your viewing of the records might have on you before deciding how to respond to such a request. In some cases the records or a summary may be released directly to you. In other cases, we might opt to release the records or a summary only to another licensed psychotherapist or physician.

BILLING STAFF: My Billing manager is Jennifer Sorensen. Jennifer handles the billing of all insurance billing claims, payment processing, and data entry for Susan Benaron's clients. Additionally, she may return phone calls for Susan Benaron, or contact you regarding any billing issue or question about your account. Contractually, Jennifer is under the "Cloak of Confidentiality". As the billing manager, she will have access to your identifying information, diagnosis, and treatment plans for insurance authorizations.

FAILURE TO HONOR FINANCIAL AGREEMENT: Our financial policy is explained in detail on a separate form. You should be aware, however, that failure to honor your financial obligations with us may result in disclosure of your name and amount of money owed to a collection agency or credit reporting agency.

CONSENT: I understand this Informed Consent for Treatment / Evaluation document. I have been provided with an opportunity to ask any questions needed for clarification, received answers to all such questions, and with my signature affirm that I understand it and agree to treatment without any implied guarantee as to therapy results or outcome.

I authorize and request that Susan Benaron, M.A., LMFT of Family Relational Therapy and The Play Therapy Cottage, her agents, and/or employees, carry out psychotherapeutic evaluations, treatments, and/or diagnostic procedures which now or during the course of my care as a client are advisable. I understand that the purpose of such procedures will be explained to me and will be subject to my agreement.

Client Name Printed ___________________________________ Date_______________

Client Signature ____

Parent/Guardian Name Printed___________________________________ Date_______________

Parent/Guardian Signature ____

Parent/Guardian Name Printed___________________________________ Date_______________

Parent/Guardian Signature ____

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AUTHORIZATION TO RELEASE / EXCHANGE CONFIDENTIAL INFORMATION

To provide you with the best care, it is often useful to be able to communicate with your other health care providers. If you consent to my doing that, please provide the relevant information below and sign where indicated.

Client's Name:___________________________DOB: ______________

I authorize Susan Benaron , M.A., LMFT, her agents, and employees to release / exchange confidential information concerning my medical, psychotherapeutic, and/or substance abuse evaluations and/or treatment for the purposes of planning and/or coordinating my care with other health care providers. This information may be released to or exchanged with:

Primary Care Physician: ____
Address/Telephone:____
Psychiatrist: ____
Address/Telephone: ____
Concurrent / Previous Therapist: ___________________________________
Address/Telephone: ____
Other Health Care Provider: ______________________________________
Address/Telephone: ____

I understand there are statutes and regulations protecting the confidentiality of medical/ psychotherapeutic/substance abuse evaluation and treatment records. I understand that the information I am consenting to have released consists of such protected information. The need for this information has been explained to me, and I voluntarily give my consent for release. This consent is valid until this request is fulfilled, but is not to exceed **December 31 of the year after the date below**. I further understand that I may revoke this consent at any time except to the extent that action based on this consent has already been taken.

__________________________________ _______________________
Signature of Client Date

__________________________________ _______________________
Signature of Parent, Guardian, Date
or Authorized Representative of Client

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FINANCIAL POLICY FOR PSYCHOTHERAPEUTIC SERVICES

PAYMENT FOR SERVICE: Standard fees for the clinicians of Family Relational Therapy and The Play Therapy Cottage are:

$125.00	Diagnostic Interview
$100.00	per 45 to 50-minute individual or family therapy session
$100.00	per hour for other clinical services (e.g., telephone contacts to/for the client, requested letters or reports written by the therapist)
$200.00	per hour for forensic psychotherapeutic services (e.g., evaluations for courts or legal proceedings, letters to attorneys, court testimony, travel time to and from the court, time required to be at the court for testimony)

If the therapist is a contracted provider with your insurance company or health care coverage organization, the billing fees and procedures will coincide with the terms of the provider contract. If your therapist is not a contracted provider with your insurance company, we require the first visit to be paid for at the time of service. For subsequent visits you may be able to pay only the portion that your insurance is not expected to cover. Clients are expected to pay for the portion of the cost for which they are responsible with cash, check, or money order at the time the services are rendered. If an extraordinary situation arises that warrants an exception to this policy, the client, with the agreement of the therapist, may carry a small balance and make reasonable monthly payments. A re-billing fee of $10 will be charged every month for which no payment is received. Failure to maintain the agreed monthly payments, as demonstrated by two consecutive months of non-payment, may result in some type of collection action. Please notify us if a problem arises regarding your ability to make timely payment.

Telephone contacts to/for the client, as well as requested letters or reports written by the therapist, are billed at the standard hourly rate for clinical services. Typically insurance will not cover these types of charges so the client will be asked to pay for such services directly.

Requests for records will be handled with consideration of relevant and ethical legal guidelines. Charges for copying records or reports will vary depending on the size of the record, but will be a minimum of $15.

NON-PAYMENT OF BILL: If you fail to pay your bill, actions may be taken to collect the unpaid balance. Such actions may include use of a collection agency, court litigation, a negative credit report, and/or filing a 1099-C with the IRS. If it becomes necessary to use any of the above-mentioned actions, the costs to your therapist will be added to your account balance. Additionally, your name, address, and telephone, along with the balance you owe, may be disclosed as necessary. No other information about your treatment will be revealed.

INSURANCE REIMBURSEMENT: Clients who carry insurance should remember that professional services are rendered and charged to the client, not the insurance company. Your insurance company may or may not reimburse for services at the same rate that your therapist charges. Nonetheless, you, not the insurance company, are responsible for any portion of the bill not paid by the insurance company unless we have a contract with your insurance company that prohibits us from billing you for certain charges. We are not responsible for negotiating with your insurance company for payment. You will be given a receipt of services so that you can request reimbursement from your insurance carrier if you desire. You should also be aware that submitting a claim to insurance or other third party payor for reimbursement may require disclosure of some aspects of your treatment (e.g., symptoms, diagnosis, treatment plan, and/or treatment progress). A request for us to submit a claim to your insurance carrier or other third party payor is considered consent for us to release information needed to adjudicate the claim. Only the information necessary to process your claim will be released unless additional consent is obtained.

CANCELLATION OF APPOINTMENT: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for rescheduling or cancellation of an appointment. **A $25 charge will apply the first time a client cancels an appointment late or fails to keep an appointment. Half of the therapist's regular hourly fee will be charged for subsequent missed sessions without cancellation notice 24 hours in advance.**

____ ____
Client's Name Printed Responsible Party Name Printed (if different than client)

I have read this financial policy. I have been provided with an opportunity to ask any questions needed for clarification, and with my signature affirm that I understand and agree to abide by this policy. **I accept financial responsibility for services rendered to the above-named client.**

____ ________________
Responsible Party Signature Date

Billing address: ____, ____________________
Street address Apt or Suite

____, ___________________________ _____________
City State Zip

(_______) _______ - ___________
Phone

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118 Nevada Arroyo Grande, Cal. 93420
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TO MY CLIENTS

I ask for your help regarding a problem that I am having in this practice. Because my schedule is so full, many of my clients feel that they have to wait too long to schedule an appointment. On the other hand, I have many clients who do not show up for their appointments. Often I have several missed appointments in a single day. This causes problems for all of us. When someone misses an appointment without notice, I cannot offer that time to another client. Additionally, when a client misses an appointment, I must reschedule them. This uses yet another time slot, which means that the other clients must now wait that much longer for an open appointment time. To better serve all of you clients I have instituted the following policy.

Missed Appointment Policy

- 24 hour advanced notice is required to cancel appointments. An appointment canceled with less than 24 hours notice will be considered a missed appointment.
- The first missed appointment will result in a $25.00 charge.
- The second missed appointment will result in $50.00 charge.
- The third missed appointment will result in a full-fee charge, and or discharge from the practice.

I understand that everyone leads busy lives, everyone forgets sometimes, and emergencies do happen. So, in an emergency or unavoidable situation, please call as soon as you can prior to your appointment in order to cancel and reschedule. Please explain the reason for canceling your appointment. I will make reasonable exceptions to my policy on an individual basis.

Some programs, such as MediCal, prohibit billing clients. In these cases we will issue a warning after the first missed appointment and the client will be discharged after the second missed appointment.

Please sign below to indicate that you have been informed of this policy. Please be advised that missed appointment charges are considered non-covered services, and will not be paid by medical insurance. You will be responsible for the payment of these charges. Missed appointment charges will be collected at the beginning of the next rescheduled visit.

_________________________ ___________________________ _________
Client Name Signature of Client Date

I hope you understand the need for this policy. Thank you for keeping you appointments and thereby helping me schedule appointments for all my clients in a timely manner.

Susan Benaron, MA, LMFT
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Authorization to Bill Insurance / Third Party Payor

Client: ____

Client's date of birth: ________/________/______________

Primary Insurance or Payor:
____

Name of Insured: ____

Relationship of insured to client: _______________________

Insured's Policy or ID #: ____

Group #: ________________________________

Insured's date of birth (if different than client's): ________/_______/_______________

Insured's phone #: (________) ________ - __________

Insured's address (if different than client's):

____
street city state zip

Insured's employer:
____

Employer address:
____

Employer phone #:
____

Secondary Insurance or Payor:
____

Name of Insured: ____

Relationship of insured to client: _______________________

Insured's Policy or ID #: ____

Group #: _______________________________________

Insured's date of birth (if different than client's): ________/_______/_______________

Insured's phone #: (________) ________ - __________

Insured's address (if different than client's):

____
street city state zip

Insured's employer:
____

Employer address:
____

Employer phone #:
____

Authorization and Assignment

I authorize Susan Benaron , M.A., LMFT of Family Relational Therapy and The Play Therapy Cottage to furnish all information requested by the above-listed insurance companies or third party payors about my illness or injury to process a claim. I also authorize the insurance companies or third party payors to make payable to Susan Benaron, M.A., LMFT any medical benefits that may be due to me per my policy as a result of my illness or injury.

If applicable, I authorize Susan Benaron MA., LMFT to release to the Social Security Administration or its intermediaries or carriers, or to the billing agent of this group, any information needed for this or a related Medicare or Medi-Cal claim.

I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits to the party who accepts assignment.

I understand that Susan Benaron, M.A., LMFT does not accept responsibility for collection of my insurance / health care benefits or negotiating the settlement of a disputed claim. I am responsible for payment of all charges regardless of anticipated coverage.

____ ____________
Responsible party Date

HIPAA Notice of Privacy Procedures and Policies

THROUGHOUT THIS DOCUMENT, THE PRONOUNS "I", "ME", AND "MY" REFER TO YOUR THERAPIST AND/OR HIS/HER AGENTS.

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

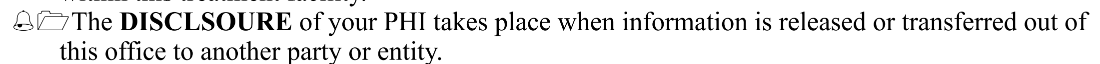
A. I am required by legal statue to protect the privacy of your health information. This "personal health information" is defined as that health information that can be used to identify you, has been created by my office, or has been received from another office or entity. It applies to past, present, and future health or condition, your treatment, payment for services, and other health practices, which will be explained to you.

B. My office is legally required to apply/follow the practices described in this **NOTICE.**

C. My office has the right to change the privacy practices as described in this **NOTICE** at any time, as permitted by law. The changes will apply to your health information held by my office. You will receive an updated copy of the **NOTICE** and it will be posted in my office. You can request a copy of this **NOTICE** at any time by notifying the **CONTACT OFFICER** at the address and telephone listed at top of this page.

III. HOW I MAY USE AND DISCLOSE YOU PHI

The **USE** of your PHI applies to sharing utilization, examination, or analysis of the information within this treatment facility.


The **DISCLSOURE** of your PHI takes place when information is released or transferred out of this office to another party or entity.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations That Do Not Require Your Prior Written Consent. My office can use and disclose your PHI <u>without</u> your consent for the following reasons:

1. **For Treatment.** Your PHI can be used within my practice to provide you with mental health treatment including discussing or sharing your PHI with trainees and interns. My office can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.
2. **To Obtain Payment for Treatment.** Use and disclosure of your PHI is permitted in order to bill and collect payment for the treatment and services provided to you by my office. These disclosures are limited in scope and serve to provide insurance companies or other third party payors with only the necessary information needed to process payment for your treatment. For example, I might send your PHI to your insurance company or health plan to be paid for the health care services that I have provided to you that might include, but not limited to, your name, social security number, diagnosis, treatment plan, fee charged, insurance number, dates of service and other essential information to process your claim. I also may provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims.
3. **For Health Care Operations.** My office can use and disclose your PHI to operate the practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provide such services to you. I also may provide your PHI to accountants, attorneys, consultants, or others to further health care operations.
4. **For Research Purposes.** My office can release limited confidential health information for research purposes.
5. **Patient Emergency.** My office may disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent is not required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me. (For example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. My office can use and disclose your PHI without your consent or authorization for the following

reasons:

1. When federal, state, and local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.
2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I also may have to use or disclose your PHI in response to a subpoena.
3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant
4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.
5. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization
6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health and safety of others. However, any such disclosures will be made only to someone who might be able to prevent the threatened harm from occurring.
7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.
8. To remind you about appointments.
9. A limited data set of your PHI can be released for research purposes without your consent. If fully identifiable health information is needed for research purposes, an authorization for release of information must be signed before information is released.

C. Other Uses and Disclosures Require Your Prior Written Authorization.

In any other situation not described in section III, your written authorization before using or disclosing any of your PHI is required. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I have not taken any action in relation to such authorization) of your PHI. I also will need to obtain an authorization before releasing your psychotherapy notes. "*Psychotherapy notes*" are notes I have made about our conversation during a private, group, joint, or family counseling sessions, which I have kept separate from the rest of your health record. These notes are given a greater degree of protection than PHI and written authorization will be obtained before psychotherapy notes are released.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Restrictions on Uses and Disclosures. You have the right to request restrictions or limitations on uses or disclosures of your PHI to carry out treatment, payment, or health care operations. Please submit such requests to my office in writing, I will consider your requests, but I am not legally required to accept them. If your requests are accepted, I will put them in writing and my office will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.

B. The Right to Choose How I Send PHI to You. You have the right to request that I send confidential information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and when appropriate, you provide me with information as to how payment (if required) for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communication on a confidential basis.

C. The Right to Inspect and Receive a Copy of Your PHI.

1. In most cases, you have the right to inspect and receive a copy of the PHI that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I do not have your PHI but I know who does, I will tell you who does, and I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, the reasons for the denial and explain your right to have the denial reviewed.

2. If you request copies of your PHI, I will charge you not more than $ .50 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.
3. Minors have the right to access their records when:
   a. The minor may legally obtain treatment without parental consent
   b. The parents sign a confidentiality waiver
   c. The minor can provide the consent for treatment
   d. Parents can access the minor's records when such access is permitted or required by law.

D. **The Right to Receive a List of the Disclosures Made By My Office.** You generally have the right to receive an Accounting of Disclosures of PHI for which you have provided neither consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

E. **The Right to Amend Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. Upon request, I will discuss with you the details of the amendment process.

F. **The Right to Receive a Paper Copy of This Notice.** You have the right to receive a paper copy of my notice even if you have agreed to receive it via e-mail.

V. HOW TO COMPLAIN ABOUT PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a compliant with the person listed in Section VI below. You also may send a written compliant to the Secretary of the Department of Health and Human Services at 200 Independence Avenue.S.W., Washington, D.D. 20201. I will take no retaliatory action against you if you file a complaint about my office's privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT MY NOTICE OR TO COMPLAIN ABOUT PRIVACY PRACTICES

If you have any questions about my notice or any complaints about the privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact Susan Benaron at: (805) 346-1999.

VII. EFFECTIVE DATE OF MY NOTICE

This notice will go into effect September 1, 2003.

I will limit the uses or disclosures that I will make as follows:

It is customary among mental health professionals to limit use and disclosure of confidential information to those that the client has specifically consented, those required by law (e.g., reporting suspected child abuse, etc), and in litigation procedures against you or myself. My office will abide by that standard when it is prudent to so. There may be exceptions and in those cases where I reasonably believe that, it is in your best interest that I disclose information even without your specific consent. An example of such a situation might be if you needed emergency treatment and information I provided would help to ensure that you received appropriate care.

Susan Benaron, MA, LMFT
118 Nevada Arroyo Grande, Cal. 93420
805-270-3558 phone 805-481-1801 fax

Name of Contact Officer: Susan Benaron

ACKNOWLEDGEMENT OF RECEPT OF NOTICE OF PRIVACY PRACTICES

You have the right to refuse to sign this document

I ____, have received a copy of the Notice of Privacy Practices.

Patient's Printed Name: ____

Signature

____

Date:

____

FOR OFFICE USE ONLY

My office attempted to obtain written acknowledgment of receipt of the NOTICE of Privacy Practices, however, we were unable to obtain it because:

_____ The patient refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented my office from obtaining the acknowledgment

Other (see below)

____

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