Encounter Freedom Therapy Center
6611 E. Central Ave Suite C
Wichita, KS 67206
(316) 358-7140

COUPLES THERAPY INTAKE PACKET

NAME: _____ _____ _____
First Name | Middle Initial | Last Name

DOB: _____ **AGE:** _____ **SEX:** ☐ Male ☐ Female

OCCUPATION: _____ **HIGHEST LEVEL OF EDUCATION:** _____

NAME: _____ _____ _____
First Name | Middle Initial | Last Name

DOB: _____ **AGE:** _____ **SEX:** ☐ Male ☐ Female

OCCUPATION: _____ **HIGHEST LEVEL OF EDUCATION:** _____

ADDRESS: _____ **APT #:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE NUMBER: _____ _____ _____
Home | Cell | Work

_____ _____ _____
Cell | Cell | Work

E-MAIL ADDRESS: _____

E-MAIL ADDRESS: _____

IN CASE OF AN EMERGENCY PLEASE IDENTIFY ONE PERSON YOU AUTHORIZE YOUR CLINICIAN TO CONTACT:

NAME: _____ **PHONE NUMBER:** _____

RELATIONSHIP TO YOU: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER _____

ARE YOU SATISFIED WITH YOUR ROMANTIC LIFE? _____

PLEASE LIST ALL PERSONS LIVING WITH YOU *AND OTHERS* THAT ARE MOST IMPORTANT IN YOUR LIFE: CHILDREN, PARENTS, SIBLINGS, FRIENDS, ETC.: (*PLEASE USE BACK OF DOCUMENT IF NECESSARY)*

	NAME	RELATIONSHIP	DOB & AGE	PERSONALITY	OCCUPATION/LEVEL OF EDUCATION	COHABITANT?
1.						
2.						
3.						
4.						
5.						
6.						

HOW DID YOU HEAR ABOUT US: _____

IS TREATMENT COURT ORDERED? ☐ Yes ☐ No **ARE YOU SEEKING DISABILITY?** ☐ Yes ☐ No

SPIRITUALITY:

Do you have a religion or faith? ☐ Yes ☐ No If yes, what religion or faith do you belong to?_____

Would you describe your spiritual beliefs as producing: ☐ Comfort ☐ Stress ☐ N/A

Are you an active participant in a religious community? ☐ Yes ☐ No

Would you like the counseling process to include scripture discussion or prayer?

Scripture discussion: ☐ Yes ☐ No Prayer: ☐ Yes ☐ No

INDIVIDUAL CONCERNS

THE FOLLOWING INDIVIDUAL CONCERNS ARE TO BE COMPLETED SEPARATELY

NAME: _____

WHAT PROBLEMS BRING YOU TO COUNSELING? _____

_____

WHAT DO YOU HOPE TO ACCOMPLISH IN COUNSELING? _____

WHAT CONCERNS, IF ANY, DO YOU HAVE ABOUT COUNSELING? _____

SUBSTANCE USE: Please mark each that apply to you (C = Current and P = Past)

C P	C P	C P
☐ ☐ **TOBACCO** AMOUNT PER DAY:_____	☐ ☐ **MARIJUANA** AMOUNT PER DAY:_____	☐ ☐ **OTHER:** _____ AMOUNT: _____
☐ ☐ **ALCOHOL** AMOUNT PER WEEK:_____	☐ ☐ **NON-PRESCRIPTION DRUGS** AMOUNT PER DAY:_____	

HAVE YOU EVER BEEN ARRESTED FOR DRIVING UNDER THE INFLUENCE (DUI)? ☐ Yes ☐ No

IF YES, HOW MANY TIMES?_____

SELF/FAMILY MENTAL HEALTH HISTORY: Please mark each that apply to you (S = Self, I = Immediate Family, and E = Extended Family).

S I E	S I E	S I E
☐ ☐ ☐ INDIVIDUAL THERAPY	☐ ☐ ☐ DOMESTIC VIOLENCE	☐ ☐ ☐ EMOTIONAL ABUSE
☐ ☐ ☐ MARITAL THERAPY	☐ ☐ ☐ ANGER MANAGEMENT	☐ ☐ ☐ BIPOLAR DISORDER
☐ ☐ ☐ FAMILY THERAPY	☐ ☐ ☐ AA, NA, OR CELEBRATE RECOVERY	☐ ☐ ☐ SCHIZOPHRENIA
☐ ☐ ☐ GROUP THERAPY	☐ ☐ ☐ SEXUAL ABUSE	

HAVE YOU EVER BEEN HOSPITALIZED FOR AN EMOTIONAL OR NERVOUS PROBLEM? ☐ Yes ☐ No

FAMILY MEMBER? ☐ Yes ☐ No **IF YES, WHEN AND WHERE?** _____

HOW OFTEN DO YOU THINK ABOUT SUICIDE? ☐ DAILY ☐ WEEKLY ☐ RARELY ☐ NEVER **HAVE YOU ATTEMPTED SUICIDE?** ☐ Yes ☐ No

IF YES: WHEN, HOW, AND HOW MANY ATTEMPTS?_____

DO YOU HAVE THOUGHTS OF SUICIDE NOW? ☐ Yes ☐ No **FAMILY MEMBER THOUGHTS OR ATTEMPTS?** ☐ Yes ☐ No

HAVE YOU EVER BEEN PHYSICALLY, SEXUALLY, OR EMOTIONALLY HARMED? ☐ Yes ☐ No

DO YOU HAVE ANY CONCERNS ABOUT VIOLENCE/ABUSE IN YOUR FAMILY OR HOUSEHOLD? ☐ Yes ☐ No **IF YES, PLEASE DESCRIBE** ***(CAN USE EXTRA PAGES IF NECESSARY)***

SELF/FAMILY MEDICAL HISTORY: Please mark each that apply to you (S = Self, I = Immediate Family, and E = Extended Family).

S I E

☐ ☐ ☐ ASTHMA

S I E

☐ ☐ ☐ HIGH BLOOD PRESSURE

S I E

☐ ☐ ☐ CANCER

☐ ☐ ☐ THYROID PROBLEMS

☐ ☐ ☐ HEART DISEASE

☐ ☐ ☐ ALLERGIES

☐ ☐ ☐ DENTAL PROBLEMS

☐ ☐ ☐ TUBERCULOSIS

☐ ☐ ☐ HEAD INJURY

☐ ☐ ☐ HEARING ISSUES

☐ ☐ ☐ DIABETES

☐ ☐ ☐ SEASONAL ALLERGIES

☐ ☐ ☐ SEIZURES

☐ ☐ ☐ KIDNEY DISEASE

☐ ☐ ☐ LIVER DISEASE

☐ ☐ ☐ OTHER

AVERAGE HOURS SLEPT PER NIGHT:_____ **EXERCISE FREQUENCY:**_____

ARE YOU CONCERNED ABOUT YOUR HEALTH ☐ Yes ☐ No **DATE OF LAST PHYSICAL:**_____

CURRENTLY PRESCRIBED MEDICATIONS, DOSE, PURPOSE, AND PRESCRIBING PHYSICIAN:

_____

_____

CURRENT GENERAL FUNCTIONING: Please mark each of the following below that apply to you (S = Self) or with a family member (F = Family).

S F

☐ ☐ DEPRESSED MOOD

☐ ☐ LOSS OF INTEREST OR PLEASURE

☐ ☐ LACK OF ENERGY/FATIGUE

☐ ☐ WEIGHT GAIN OR LOSS

☐ ☐ UNABLE TO CONCENTRATE

☐ ☐ EXCESSIVE SLEEPING

☐ ☐ DIFFICULTY SLEEPING

☐ ☐ DECREASED NEED FOR SLEEP

☐ ☐ PRESSURE TO KEEP TALKING

☐ ☐ RACING THOUGHTS

☐ ☐ EXCESSIVE RISK-TAKING BEHAVIOR

☐ ☐ PANIC ATTACKS

☐ ☐ EXCESSIVE FEAR OF SITUATION OR OBJECT

☐ ☐ REOCCURRING THOUGHTS OR IMPULSES

☐ ☐ REPETITIVE BEHAVIROS DUE TO INCREASED STRESS

☐ ☐ WITNESS/EXPERIENCE EVENT THREATENING LIFE OR SERIOUS INJURY

☐ ☐ EXCESSIVE ANXIETY OR WORRY

☐ ☐ HEAR/SEE THINGS OTHERS DO NOT

☐ ☐ MEMORY PROBLEMS/MEMORY LOSS

☐ ☐ SUICIDAL THOUGHTS

☐ ☐ SELF-HARMING THOUGHTS

☐ ☐ SIGNIFICANT ONGOING PHYSICAL PAIN

☐ ☐ STOMACH PROBLEMS

S F

☐ ☐ HEADACHES

☐ ☐ BOWEL PROBLEMS

☐ ☐ BALANCE PROBLEMS

☐ ☐ SEIZURE PROBLEMS

☐ ☐ LEARNING/ACADEMIC PROBLEMS

☐ ☐ PORNOGRAPHY

☐ ☐ EXCESSIVE MASTERBATION

☐ ☐ BODY IMAGE

☐ ☐ FREQUENT PROBLEMS WITH ATTENTION

☐ ☐ FREQUENT "ON THE GO" BEHAVIORS

☐ ☐ IMPULSIVE BEHAVIORS

☐ ☐ TEMPER

☐ ☐ PHYSICAL AGGRESSION

☐ ☐ DESTRUCTIVE BEHAVIORS

☐ ☐ FREQUENT LYING/DECEITFULNESS

☐ ☐ PROBLEMS FOLLOWING RULES

☐ ☐ SEXUAL PROBLEMS

☐ ☐ EATING PROBLEMS

☐ ☐ NIGHTMARES

☐ ☐ GAMBLING PROBLEMS

☐ ☐ FREQUENT FEAR(S)

☐ ☐ ALCOHOL USE

☐ ☐ DRUG USE

☐ ☐ MARITAL PROBLEMS

☐ ☐ DIVORCE

S F

☐ ☐ SEPARATION

☐ ☐ AFFAIR

☐ ☐ PROBLEMS WITH EX/SPOUSE

☐ ☐ RELATIONSHIP PROBLEMS

☐ ☐ PARENTING PROBLEMS

☐ ☐ PROBLEMS WITH FRIENDS

☐ ☐ PROBLEMS WITH CHILDREN

☐ ☐ LEGAL PROBLEMS

☐ ☐ WORK/JOB PROBLEMS

☐ ☐ FINANCIAL PROBLEMS

☐ ☐ SCHOOL PROBLEMS

☐ ☐ SHYNESS

☐ ☐ ANGER

☐ ☐ LONELINESS

☐ ☐ INSECURITY

☐ ☐ ISOLATION

☐ ☐ HALLUCINATIONS (SEEING OR HEARING THINGS THAT OTHERS MAY NOT SEE OR HEAR.)

☐ ☐ GRIEF/LOSS

☐ ☐ SAD OR TEARFUL MOST OF THE TIME

☐ ☐ FEELINGS OF GUILT

☐ ☐ SHAME

☐ ☐ POOR SELF-CARE/POOR HYGIENE

☐ ☐ STRESS

☐ ☐ AVOIDANT

☐ ☐ THREAT TO HURT SOMEONE WITH INTENT/PLAN

☐ ☐ VERBAL THREATS TO HARM OTHERS

☐ ☐ HARD TO WAKE UP IN THE MORNING

☐ ☐ PHYSICAL CRUELTY TO ANIMALS

☐ ☐ TRUST

☐ ☐ JEALOUSY

☐ ☐ CRISIS

☐ ☐ WETTING ACCIDENT

☐ ☐ TERMINAL ILLNESS

☐ ☐ CHANGE IN LIFE STAGE

☐ ☐ RECENT MOVE

AUTHORIZATION AND CONSENT

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Signature X _____ Date_____

INDIVIDUAL CONCERNS

NAME: _____

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_____

WHAT DO YOU HOPE TO ACCOMPLISH IN COUNSELING? _____

WHAT CONCERNS, IF ANY, DO YOU HAVE ABOUT COUNSELING? _____

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C	P		C	P		C	P	
☐	☐	**TOBACCO** AMOUNT PER DAY:_____	☐	☐	**MARIJUANA** AMOUNT PER DAY:_____	☐	☐	**OTHER:** _____ AMOUNT: _____
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S	I	E		S	I	E		S	I	E	
☐	☐	☐	INDIVIDUAL THERAPY	☐	☐	☐	DOMESTIC VIOLENCE	☐	☐	☐	EMOTIONAL ABUSE
☐	☐	☐	MARITAL THERAPY	☐	☐	☐	ANGER MANAGEMENT	☐	☐	☐	BIPOLAR DISORDER
☐	☐	☐	FAMILY THERAPY	☐	☐	☐	AA, NA, OR CELEBRATE RECOVERY	☐	☐	☐	SCHIZOPHRENIA
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S	I	E		S	I	E		S	I	E	
☐	☐	☐	ASTHMA	☐	☐	☐	DENTAL PROBLEMS	☐	☐	☐	SEIZURES
☐	☐	☐	HIGH BLOOD PRESSURE	☐	☐	☐	TUBERCULOSIS	☐	☐	☐	KIDNEY DISEASE
☐	☐	☐	CANCER	☐	☐	☐	HEAD INJURY	☐	☐	☐	LIVER DISEASE
☐	☐	☐	THYROID PROBLEMS	☐	☐	☐	HEARING ISSUES	☐	☐	☐	ALLERGIES
☐	☐	☐	HEART DISEASE	☐	☐	☐	DIABETES	☐	☐	☐	OTHER
				☐	☐	☐	SEASONAL ALLERGIES				

AVERAGE HOURS SLEPT PER NIGHT:_____ **EXERCISE FREQUENCY:**_____

ARE YOU CONCERNED ABOUT YOUR HEALTH ☐ Yes ☐ No **DATE OF LAST PHYSICAL:**_____

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_____

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☐	☐	LOSS OF INTEREST OR PLEASURE
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☐	☐	BOWEL PROBLEMS
☐	☐	BALANCE PROBLEMS

S	F	
☐	☐	SEIZURE PROBLEMS
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☐	☐	AFFAIR
☐	☐	PROBLEMS WITH EX/SPOUSE
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☐	☐	PARENTING PROBLEMS
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S	F	
☐	☐	LEGAL PROBLEMS
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☐	☐	TRUST
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☐	☐	CRISIS
☐	☐	WETTING ACCIDENT
☐	☐	TERMINAL ILLNESS
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☐	☐	RECENT MOVE

AUTHORIZATION AND CONSENT

By signing below you are authorizing Encounter Freedom Therapy to provide you with mental health services. (MUST BE SIGNED BEFORE SERVICES CAN BE PROVIDED)

Signature X _____ **Date**_____

BILLING POLICY

*If billing information is not complete and accurate, we reserve the right to **NOT** schedule additional appointments until it is supplied.* ***Please be advised that your confidentiality may be compromised when your bill/payment is submitted to your insurance company, banking corporation, third-party payers, and/or credit card company. Encounter Freedom Therapy and the individual practices of the therapists therein assume no responsibility if your confidentiality is compromised during the billing/payment process.***

PAYMENT OPTION: ☐ INSURANCE ☐ SELF-PAY ☐ OTHER _____

PRIMARY INSURANCE POLICY INFORMATION:

Primary Insurance Company: _____

Insurance Member I.D. Number: _____

Insurance Group Number (or none): _____ Effective Date: _____

PRIMARY INSURANCE INSURED PERSON INFORMATION:

Client's relationship to insured (i.e. self, spouse, child, other): _____

Insured Name: _____

Insured's Street Address: _____

Insured's City: _____ Insured's State: _____ Insured's Zip Code: _____

Insured's Phone Number: _____

Insured's Date of Birth: _____ Insured's Gender: ☐ Male ☐ Female

Insured's Employer: _____

Deductible Amount: _____ Copay Amount: _____

By signing this agreement below you agree to and acknowledge each of the following conditions.

1. The information provided regarding insurance coverage is accurate.
2. Payment for any and all required co-payments, deductibles, coinsurance and non-allowable charges is required and due at the time the service is delivered. Payment must be in the form of cash, check or credit cards.
3. If your insurance company denies, refuses, or fails to make payments for the services rendered, your therapist will notify you in writing. You are then responsible to cover the full amount for services rendered.
4. You assume responsibility for any and all fee's rendered associated with services including document preparation fees provided by your therapist at Encounter Freedom Therapy.
5. You will be solely responsible for the full cost of the session if you do not show up for your appointment or do not cancel at least 24 hours in advance.
6. Insufficient fund checks will be assessed a $30.00 charge.
7. You are responsible for notifying your therapist of any changes in name, address, telephone number or insurance coverage.
8. By signing this agreement, you agree to allow your therapist to release any and all information necessary for filing insurance claims and collecting fees from your insurance company.
9. Your therapist shall have the authority to charge and assess collection costs and expenses, including reasonable attorney's fees, and penalties and interest for the late payment or nonpayment thereof.
10. Any additional services including but not limited to court reports and/or court letters, court testimony, disability paperwork, professional letters, etc. will be charged at a rate of $150.00 dollars per hour.

Print Name _____ Date _____ Print Name _____ Date _____

Signature _____ Signature _____

Encounter Freedom Therapy Center
6611 E. Central Ave Suite C
Wichita, KS 67206
(316) 358-7140

Informed Consent
Agreement for Therapeutic Services

As a client(s), you have certain rights and responsibilities. Those rights and responsibilities are outlined below. Each member participating in therapy should read and initial each blank on this form. Signing this form indicates acceptance of these terms for provision of services:

_____1) _____ You have the right to ask questions about your therapy. Your clinician will explain his/her therapy approach and methods used if you would like. Your clinician will also discuss the Code of Ethics under which he/she practices if you desire.

_____2) _____ You or your clinician have the right to end therapy at any time without any moral, legal or financial obligations other than those already incurred. We request that if the decision is made to terminate, that a final session be scheduled to explore the reasons for termination. If a final session is not scheduled, your clinician may contact you to request feedback regarding termination. Termination itself can be a constructive and useful process. If a referral is desired, it will be made at this time.

_____3) _____ You have the right to specify and negotiate therapeutic goals and to renegotiate when necessary. You have the responsibility to provide us with accurate information as to how we might best help you and to keep us advised of your needs throughout the therapeutic process.

_____4) _____ You have the right to be fully informed about fees for therapy and the method of payment required.

_____5) _____ In order to communicate with insurance panels, it may be necessary to contact and share information regarding diagnosis, type of contact, frequency and duration of sessions with your specific provider.

_____6) _____ You have the right to confidentiality within certain limits. Information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency with the following exceptions:

a) you sign a written release of information indicating informed consent to such release;
b) you express serious intent to harm yourself or someone else;
c) there is evidence or reasonable suspicion of abuse against a minor child, elder person or dependent adult;
d) a subpoena or other court order is received directing the disclosure of information (it is our policy to assert privileged communication in such a situation);
e) you are in therapy or being tested by order of a court of law (the results of the treatment or test ordered must be revealed to the court); and
f) case consultation between the clinician and his/her clinical peers.

_____7) _____ You understand that suicide risk is to be taken very seriously. You want help in finding new ways to manage stress in times of crisis. You realize there are no guarantees about how crises resolve, and that your clinician is making reasonable efforts to maintain safety for everyone. You understand that in some cases hospitalization may be necessary.

_____ 8) _____ In working to achieve the potential benefits of therapy, it may require that you make firm efforts to change and it may involve experiencing significant discomfort. Remembering and therapeutically resolving unpleasant events can arouse intense feelings of fear, anger, depression, frustration, and the like. Seeking to resolve issues between family members, marital partners, and other persons can similarly lead to discomfort, as well relationship changes that may not be originally intended.

_____ 9) _____ Appointments are scheduled for 50 minutes, known as a "clinical" hour. The remaining 10 minutes on the "clock" hour is used by your clinician to maintain your file. Clients are expected to keep appointments as scheduled. **Because the appointment time is reserved for you, it is necessary to charge for appointments which are not canceled 24 hours in advance,** unless in fact they are occasioned by circumstances which we would both define as an emergency. You the client will be solely responsible for the full cost of the canceled or missed session. If you must cancel or reschedule, notify the clinician as far in advance as possible.

_____ 10) _____ You understand that all information is confidential according to HIPAA (Health Insurance Portability and Accountability Act) standards. Reception of HIPAA privacy practices and acknowledgement including verbal discussion of HIPAA expectations has taken place according to your initials.

_____ 11) _____ You understand the scope of practice of the assigned clinician. Discussion of your clinician's experience and scope of practice as well as inability to perform surgery or prescribe medicine has taken place according to your initials.

_____ 13) _____ You understand that in case of your clinician's death or incapacity to personally contact you, your clinician has identified (**to be filled in by clinician)**_____at _____to have confidential access to properly contact you to either close and store your case file and/or to offer referral services to ensure continuity of care.

_____ 14) _____ Per the BSRB (Behavioral Sciences Regulatory Board) we are required to request permission or waiver to contact your primary care physician in order to consult with regard to your treatment received and related medical needs.

_____waive _____or authorize to contact _____

Physician's Name/Number

_____ 15) _____ You understand that electronic communication through unencrypted text messages or email is not secure. It is our policy to not discuss therapeutic issues at length via text or email.

_____ 16) _____ I authorize my clinician to communicate with me via text at this mobile number: _____

OR to communicate with me via email at this address: _____

Client/Guardian Signature	Date	Client Signature	Date
Client/Guardian Signature	Date	Client Signature	Date
Clinician Signature	Date	Clinician Signature	Date

NOTICE OF PRIVACY PRACTICES

Encounter Freedom Therapy

Jason Miller (316) 789-6090, Privacy Officer

Effective Date: June 17th, 2019

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

The individual clinician providing your behavioral health services collects health information about you and stores it in a chart and/or on a computer. This is your medical record. The medical record is the property of the individual clinician (this medical practice), but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

6. Required by Law. As required by law, we will use and disclose your health information, but we will limit our

use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

7. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

8. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

9. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

10. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

11. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

12. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

13. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

B. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

C. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

D. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Frank Campbell, U.S. Department of Health and Human Services, 601 East 12th St, Room 353, Kansas City, MO 64106

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.