

SWC

Welcome to Shine Wellness Clinic of Romeo! We look forward to meeting all of your clinical and whole-body wellness needs. Please fill out the information below to the best of your ability in addition to any other forms attached to this welcome sheet. Do not hesitate to ask any questions or express any concerns you may have. Thank you!

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent Name (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ May we Leave a Message? Yes No

May We Communicate Via Text? Yes No

Email: \_\_\_\_\_ May We Communicate Via Email? Yes No

Emergency Contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact Number: \_\_\_\_\_

*(For Staff Only)*

Payment for Services:

☐ Photo ID

☐ Insurance Card

**Health Insurance or Cash (Circle One)?**

Health Insurance Company: \_\_\_\_\_

Enrollee Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Deductible: \_\_\_\_\_ Co-Pay: \_\_\_\_\_

Shine Wellness Clinic  
215 North Main Street, Floor 3  
Romeo, MI 48065

## Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session.  
Please note: Information provided on this form is considered confidential.

### Personal Information

Client Name: \_\_\_\_\_ (Preferred Name) \_\_\_\_\_ Todays Date: \_\_\_\_\_

Parent/Legal Guardian (if under 18): \_\_\_\_\_

DOB: \_\_\_\_\_

Age at time of assessment: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ May we leave a message? ☐ Yes ☐ No

Cell/Work/Other Phone: \_\_\_\_\_ May we leave a message? ☐ Yes ☐ No

Email: \_\_\_\_\_ May we leave a message? ☐ Yes ☐ No

*\*Please note: Email correspondence is not considered to be a secured medium of communication.*

Were you referred by a friend, family member or professional? If so, who? \_\_\_\_\_

Sexual Identity: ☐ I prefer not to share this information:

Birth Gender (Circle One): Male Female

Identified Gender (Circle One): Male Female Gender Fluid

Sexual Preference (Circle one): Straight/Heterosexual Gay/Homosexual Bisexual/Curious

Other: \_\_\_\_\_

Marital Status:

☐ Never Married

☐ Domestic Partnership

☐ Married

☐ Separated

☐ Divorced

☐ Widowed

### Clinical History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No

☐ Yes

If so, please list previous therapist(s)/practitioner(s):

\_\_\_\_\_  
\_\_\_\_\_

Are you currently taking any prescription medications? ☐ Yes ☐ No

If yes, please list:

\_\_\_\_\_  
\_\_\_\_\_

Have you ever been prescribed psychiatric medications? ☐ Yes ☐ No

If yes, please list and provide dates:

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Have you ever been hospitalized due to a mental health condition? ☐ Yes ☐ No

If yes, please describe:

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### General and Mental Health Information

1. How would you rate your current physical health? (Please circle one)

Poor                      Unsatisfactory                      Satisfactory                      Good                      Very good

Please list any specific health problems you are currently experiencing: \_\_\_\_\_

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2. How would you rate your current sleeping habits? (Please circle one)

Poor                      Unsatisfactory                      Satisfactory                      Good                      Very good

Please list any specific sleep problems you are currently experiencing: \_\_\_\_\_

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3. How many times per week do you generally exercise? \_\_\_\_\_

4. What types of exercise do you participate in? \_\_\_\_\_

5. Please list any difficulties you experience with your appetite or eating problems: \_\_\_\_\_

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6. Are you currently experiencing overwhelming sadness, grief or depression? ☐ No ☐ Yes

If yes, for approximately how long?

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Please rate your depression and/or grief on a scale of 1-10. Ten indicates the highest in severity.

1      2      3      4      5      6      7      8      9      10

7. Are you currently experiencing anxiety, panics attacks or have any phobias? ☐ No ☐ Yes

If yes, when did you begin experiencing this and for how long?

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Please rate your anxiety, panic attacks or phobias on a scale of 1-10. Ten indicates the highest in severity.

1      2      3      4      5      6      7      8      9      10

8. Are you currently experiencing any chronic pain? ☐ No ☐ Yes

If yes, please describe: \_\_\_\_\_

Please rate your pain level on a scale of 1-10. Ten indicates the highest in severity.

1      2      3      4      5      6      7      8      9      10

If yes, do you use prescription medications (prescribed or unprescribed) to manage your pain?

☐ Yes ☐ No If so, what medications do you use?

9. Do you experience any suicidal thoughts, ideation, or behaviors? ☐ Yes ☐ No

If yes, please describe: \_\_\_\_\_

Please rate your intensity of thoughts/behavior in a level on a scale of 1-10. Ten indicates the highest in severity.

1      2      3      4      5      6      7      8      9      10

10. Do you drink alcohol more than once a week? ☐ No ☐ Yes If so, how often? \_\_\_\_\_

11. How often do you engage in medical or recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

If so, what substances do you use or experiment with? \_\_\_\_\_

12. Do you have a concern that you may have a drug or alcohol abuse issue? ☐ No ☐ Yes

13. Are you under any court orders or recommendations at this time? ☐ No ☐ Yes

Please explain your current circumstances:

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### FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obesity	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____

### ABUSE AND NEGLECT HISTORY:

Have you or an immediate family member experienced childhood or adult abuse or neglect?

<u>Please Circle</u>	<u>List Family Member including Self</u>
Verbal Abuse	yes / no _____
Emotional Abuse	yes / no _____
Physical Abuse	yes / no _____
Domestic Violence	yes / no _____
Sexual Abuse	yes / no _____
Neglect (physical, medical, financial, etc.)	yes / no _____
Removal from the Parental Home	yes / no _____
Witness or forced participation in crimes	yes / no _____
Human Trafficking	yes / no _____

Are you currently in a romantic relationship or marriage? ☐ No ☐ Yes

If yes, for how long? \_\_\_\_\_

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

1      2      3      4      5      6      7      8      9      10

What significant life changes or stressful events have you experienced recently?

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### Additional Information

1. What is your highest level of education? \_\_\_\_\_

2. Are you currently employed? ☐ No ☐ Yes

If yes, what is your current employment situation?

\_\_\_\_\_

3. Do you enjoy your work? Is there anything stressful about your current work? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes

If yes, describe your faith or belief: \_\_\_\_\_

\_\_\_\_\_

5. What are your favorite past times, hobbies or activities? \_\_\_\_\_

6. What do you consider to be some of your strengths? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. What do you consider to be some of your weaknesses? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. What would you like to accomplish out of your time in therapy? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Thank you for filling out this questionnaire! Is there anything else that you would like to tell us about yourself?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

SHINE WELLNESS CLINIC, PLLC  
215 North Main Street, Floor 3, Romeo, MI 48065  
Phone: 586-281-6815 Fax: 586-281-6816

### REFERRAL PROGRAM

Shine Wellness Clinic offers a referral program to any person that refers friends, family, colleagues or other community members to our agency. You have acknowledged that you may have been referred to SWC by a friend, family, colleague or other community member. This acknowledgement entitles the person who referred you to an incentive such as a free service, product or discount but only if you wish to allow SWC to inform the individual of his or her successful referral. You are under no obligation to release this information as it is your right to maintain complete confidentiality.

### AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Guardian's Name (if under 18 years old): \_\_\_\_\_

This information may be disclosed and used by the following individual:

Referral Name: \_\_\_\_\_ Referral Phone: \_\_\_\_\_

- ☐ I authorize Shine Wellness Clinic to acknowledge to the above-named person of their successful referral. I understand that no other personal information regarding my status or case information will be shared with the named individual.
- ☐ I **do not** authorize Shine Wellness Clinic to acknowledge to the above-named person of their successful referral. I wish to keep the referral to Shine Wellness Clinic confidential. I understand that the person that referred me to SWC will not be able to receive an incentive for their referral.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X \_\_\_\_\_ & Date: \_\_\_\_\_

Signature of Patient / Parent / Guardian

X \_\_\_\_\_ & Date: \_\_\_\_\_

Printed name of Authorized Representative of Shine Wellness Clinic, PLLC.

## AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD

(Also known as Protected Health Information)

PATIENT NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address (Mailing) \_\_\_\_\_ Phone \_\_\_\_\_

I, \_\_\_\_\_, authorize Shine Wellness Clinic to use or disclose information from my mental health record, which may include information about psychiatric diagnosis and treatment and substance abuse issues to:

Name: \_\_\_\_\_ Phone \_\_\_\_\_  
Address: \_\_\_\_\_ FAX \_\_\_\_\_  
\_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

Information to be released (Please describe) \_\_\_\_\_

Purpose of Disclosure \_\_\_\_\_

1. I understand that, unless withdrawn, this authorization will expire 180 days from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Shine Wellness Clinic at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
4. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
5. My health care and payment for my health care at Shine Wellness Clinic will not be affected if I do not sign this form.
6. I understand that I can request a copy of this form after I sign it.
7. I understand that in compliance with Michigan general statute.

By signing below, I acknowledge that I have read and understand this Authorization.

\_\_\_\_\_  
Signature of Patient      Date      and/OR      Parent/Legal Guardian/Authorized Person      Date

### Client Consent to Psychotherapy:

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I consent to the use of a diagnosis in billing, and to the release of that information to my insurance company if I request so. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with Naomi M. Baba, MSW, LMSW. I understand that I can terminate my treatment at any time, and I can refuse any requests or suggestions made by Shine Wellness Clinic professionals.

### Fees and Cancellation Policy: Please initial each box below

\_\_\_\_\_ I agree to pay \$125.00 per session at the beginning of each session unless other arrangements have been made.

\_\_\_\_\_ I agree to pay \$40.00 per session for all "No Show/No Call" of scheduled sessions.

\_\_\_\_\_ (3) Three "No Show/No Call" sessions will result in closure of your case.

\_\_\_\_\_ Your case will automatically be closed if no session has been scheduled within 60 days of the last session.

Print Client's Name: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

Shine Wellness Clinic Therapist: \_\_\_\_\_ Date: \_\_\_\_\_

**Shine Wellness Clinic, PLLC**  
215 North Main Street, Floor 3  
Romeo, MI 48065

Effective Date: 05/01/2019

**Disclosure Statement and Informed Consent to Treatment**

**Your rights as a Therapy Patient:**

Therapy is a collaborative relationship between people that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy—the goal is your well-being. There are also certain legal limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you.

**My Responsibilities to You as Your Therapist:**

I. Confidentiality: With the exception of certain specific instances described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. I will always act to protect your privacy even if you do permit me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. As well, you may request anyone you wish to attend a therapy session with you.

I consult with various experts in specific fields of mental health so that I can better serve my clients. I also participate in regular group consultation. If I consult on my work with you, I will not use your name or any information that can identify you. If there is any reason to believe you might know one of these professionals, I will tell you their name so you have the option to request I do not consult with them regarding your care.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone who is doing this, I must inform Child Protective Services or the police within 24 hours.
3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police, the county crisis team or someone who can ensure your safety. I would first explore all other options with you before I took this step.

4. I may use and disclose your health information in order to bill and collect payment for the services and items you may receive from me. For example, I may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and I may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. I also may use and disclose your health information to obtain payment from third parties that may be responsible for such costs, such as family members. Also, I may use your health information to bill you directly for services and items. Usually what is only shared is the type of service I provided as well as a diagnosis from the DSM-IV (See III below).

5. Please keep in mind that although every safeguard possible is in place when using electronic communication such as email, computer, cell phone, or fax, I cannot guarantee there will be no interception. Nor can I protect your name when depositing your check at my bank if you choose to pay by check. As well, I file most insurance claims electronically, sharing your protected health information when required.

6. If you are filing a complaint or are a plaintiff in a lawsuit where you bring up the question of your mental health, you will have already automatically waived your right to the confidentiality of these records in the context of the complaint or lawsuit. Despite this, I will not release information without your signed consent or a court order. We can also discuss obtaining a protective order to help maintain confidentiality of records. Please let me know if you are in this kind of situation so that I can take the utmost care possible to protect your privacy in my records.

II. Record-keeping: I normally keep very brief records, noting that you have been here, what we did in the session, and a few words describing the topics we have discussed. If you prefer that I keep no records, you must give me a written request to this effect for your file. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file at any time. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a secure location in my office.

III. Diagnosis: If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party for you so that we can be paid. Diagnoses are the technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If I do use a diagnosis, I will discuss it with you. All diagnoses come from a published resource guide titled: DSM-V; I have a copy in my office and will be glad to let you read more about what it says about your diagnosis.

IV. Scheduled appointments. I will do my best to have a regularly scheduled appointment time for you. If I need to cancel for some unforeseen circumstance, I will do my best to get a hold of you as soon as possible and do my best to accommodate you. I will tell you well in advance of any planned absences.

### **Your Rights as a Therapy Client**

I. You have the right to ask questions about anything that happens in therapy. I am always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me

about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

II. You have the right and responsibility to decide whether the proposed treatment plan will provide you with the treatment that you want. At any point during treatment you are encouraged to let me know if something does not feel right, or if you want something else from treatment. Your input into the process of therapy, no matter how hard to put into words, is very important.

III. You have the right to confidential and safe treatment. As I said before what you say to me is confidential unless I am concerned about your safety or the safety of another person.

### **Your Responsibilities as a Therapy Client**

I. You are responsible for coming to your sessions on time and at the time we have scheduled. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than twenty-four hours' notice, you must pay for that session at our next regularly scheduled meeting.

II. You are responsible for paying for your session or your child's session at the beginning of each session unless we have made other firm arrangements in advance. My fee is typically \$125.00 for a 50-minute session. Please let me know if you feel that the fee is unaffordable - I am willing to make some adjustments depending on your personal circumstances. If we decide to meet for a long session, I will bill you prorated on the hourly fee. Emergency phone calls are normally free. However, if we regularly spend more than fifteen minutes weekly on the phone, I will bill you on a prorated hourly basis.

1. Please check with me to see if I can be reimbursed directly by your insurance company. If I am not a preferred provider under your insurance, I will help you as best I can so that you might be reimbursed by your insurance company. In that case, it is your responsibility to pay my fee, and provide me with the correct forms and information necessary for you to be reimbursed, unless otherwise arranged.

2. If you end up having an outstanding bill with me and we have terminated therapy, I expect you to pay resolve any outstanding bills. If you refuse to pay your debt, I reserve the right to give your name and the amount due to a collection agency.

3. Complaints: If you are unhappy with what's happening in therapy, I hope you'll talk about it with me so that I can respond to your concerns. I will take such criticism seriously and with care and respect. If you believe that I have behaved unethically, you have the right to file a formal complaint at: Michigan Department of Licensing and Regulatory Affairs, Phone: 517-373-9196.

### **Naomi M. Baba: My Training and Approach to Therapy**

I am a fully licensed clinical social worker in the State of Michigan (License: 6801091649). I have a Masters in Clinical Social Work from Michigan State University. I have a BA in Social Work from the University of Michigan.

My approaches to therapy are grounded in cognitive behavioral treatment, family systems, harm reduction, and are viewed through a lens of human development. I use a variety of techniques in therapy and will try to find what will work best for you. These techniques may include cognitive

reframing, training in mindfulness, distress tolerance, and emotional regulation, awareness exercises, self-monitoring, behavioral analysis, journal-keeping, and reading books. If I propose a specific technique that may have special risks attached, I will inform you of that, and discuss with you the risks and benefits of what I am suggesting.

### **Kimberly Hazel: My Training and Approach to Therapy**

I am a fully licensed clinical social worker in the State of Michigan (License: 6801065462) and a Registered Play Therapist by the Association for Play Therapy. I have a Masters in Clinical Social Work from Wayne State University. I have a BA in Sociology & Spanish from Central Michigan University.

My approaches to therapy are grounded in cognitive behavioral treatment, family systems, harm reduction, and are viewed through a lens of human development. I use a variety of techniques in therapy and will try to find what will work best for you. These techniques may include Child-centered and directive play therapy, sand tray therapy, cognitive reframing, training in mindfulness, distress tolerance, and emotional regulation, awareness exercises, self-monitoring, behavioral analysis, journal-keeping, and reading books. If I propose a specific technique that may have special risks attached, I will inform you of that, and discuss with you the risks and benefits of what I am suggesting.

**Shine Wellness Clinic, PLLC**  
**215 North Main Street, Floor 3**  
**586-218-6815**

**Notice of Privacy Practices**  
**Patient Acknowledgement**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to patient (if signed by a personal representative of patient):

\_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

Shine Wellness Clinic, PLLC- 215 North Main Street, Romeo, MI 48065

Privacy Officer: Naomi M. Baba, Owner/Director, 810-531-5333

Effective Date:07/01/2017

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.

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

This medical practice collects health information about you and stores it in a chart [and on a computer][and in an electronic health record/personal health record]. This is your medical record. The medical record is the property of 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. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.
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. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
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. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. [Participants in organized health care arrangements only should add: We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.]
4. **[Optional]: 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. **Sign In Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. 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.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. 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.

10. 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.

11. 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.

12. 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.

13. 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.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. 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.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. 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. [Note: Only

use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your email address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.].

[Add the following three activities, or any of the three, if the organization engages or intends to engage in these activities.]

22. 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.

23. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

24. Fundraising. We may use or disclose your demographic information in order to contact you for our fundraising activities. For example, we may use the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status to identify individuals that may be interested in participating in fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Officer if you decide you want to start receiving these solicitations again.

#### B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

#### C. 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 an 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.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

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.

D. 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: [www.shinewellnessclinic.org](http://www.shinewellnessclinic.org).

#### E. 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: [OCRMail@hhs.gov](mailto:OCRMail@hhs.gov).

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