**Martha E. Reynolds-Adkins, PH.D.**

**Clinical Mental Health Counselor**

**Ohio Professional Clinical Counselor**

**License # E2535**

**3 W. Stimson Ave, Suite 2**

**Athens, OH 45701**

**Office: (740) 508-2202**

**Fax: (833) 589-1711**

Thank you, for the opportunity to serve your counseling needs. The following information is designed to inform you about my background, office procedures, our professional relationship and basic information about my practice.

**Professional Qualifications and Experience**

I have been licensed as a Professional Clinical Mental Health Counselor with Supervisor Status, (in the state of Ohio) since 1997. I hold a Bachelor’s degree in Cross Cultural Communication from Ohio Christian University; have a Master’s degree in Community Counseling from Ohio University and I hold a Doctorate in Clinical Counseling from the same institution. I have been providing therapy to individuals, families, couples and groups in a community setting since 1995.

*My treatment areas as a therapist include, but are not limited to:*

* Educational, Personal, and Social Adjustment Counseling
* Relationship and family issues
* Trauma, abuse, stress and anxiety issues
* Clients experiencing spiritual dissonance
* Counseling people who experience co-occurring mental illness and substance abuse issues

**Independent Practice**

I am an independent practitioner and I am not affiliated with any other practice sharing the office space at 507 Richland Ave, Athens, Ohio 45701. This means that I maintain your records and clinical information separately and am solely responsible for your treatment. I work alone but not in isolation. I share this office suite with colleagues and we provide ongoing consultation for each other.

I welcome any questions you may have about your therapy. If during the course of your therapy you have any questions about the nature of your therapy or about fees, please feel free to discuss your concerns with me. If you have become unhappy with the service you are receiving, it is important that you try your best to communicate the sources of your dissatisfaction to me. And, if it becomes necessary, I will do my very best to help you locate a more suitable referral or therapy resource. The notes I keep on you are minimal. If you want me to keep extensive notes, let’s talk about the pros and cons.

In my private practice, I accept only clients whom I believe have the capacity to resolve their own problems with my assistance. I believe that as people become more self-aware and accepting of themselves, while concurrently making behavioral changes and learning to set limits, they become free in their relationships and in their lives. However, self-awareness, self-acceptance, and the implementation of behavioral changes are goals reached in various time frames. My approach to psychotherapy is an integrationist approach. This is a philosophy of psychotherapy that is flexible and allows me to blend a variety of ideas, theories and techniques. These modalities and techniques are likely to include cognitive-behavioral therapy, motivational interviewing, dialectical-behavioral therapy, feminist theory, multiculturalism and some psychodynamic theories about how past experiences shape one’s self concept and image. Techniques may include dialogue, interpretation, behavioral exercises, cognitive reframing, awareness exercises, self-monitoring experiments, visualization, journal-keeping, drawing, and reading books. We will work together to achieve your goals in a timely manner. You have the right to refuse anything that I suggest. I do not have social or sexual relationships with clients or former clients because that would not only be unethical and illegal, it would be an abuse of the power I have as a therapist. If you are involved with a judicial issue or need a specific assessment in order to comply with an academic or court requirement, I want you to know that **I do not go to court as an advocate** **and do not do those types of assessments.** I also **do not do custody evaluations of any kind.** If you are looking for a therapist for forensic reasons, I can refer you to someone else. During the course of counseling we will need to evaluate the process and progress of therapy periodically and renegotiate the need for further sessions.

**Appointments**

Appointments may be scheduled as needed either at the end of the session, by phone or by email. You can leave a message at (740-508-2202) and I will return the call as soon as possible. My email is [mreynoldsadkins@yahoo.com](mailto:mreynoldsadkins@yahoo.com).

**Cancellations and Missed Appointments**

If it is necessary to cancel an appointment, a 24 hour notification would be appreciated. You may call and leave a message for me at (740)508-2202 or email [mreynoldsadkins@yahoo.com](mailto:mreynoldsadkins@yahoo.com). It is important to note that you will be billed at half the usual rate for appointments that have not been cancelled 24 hours in advance. If you are using your insurance to defray the cost of this service, be aware that most insurance policies will not pay for missed sessions, leaving you fully responsible for the cost. Please just call or email if you cannot attend a scheduled appointment.

**Termination of Services**

You may terminate counseling at any point and I will be respectful and supportive of your decision. However, termination is most efficacious if we have the opportunity to discuss and make the decision together. If you fail to show for a scheduled appointment and do not call to reschedule within 48 hours, I will assume you have chosen to terminate therapy.

**Emergencies**

Occasionally, you may need to contact me in an emergency. Emergency appointments can be scheduled as you and I deem necessary. If you feel there is a danger of harming yourself or someone else, immediately contact me. In the event that I am unavailable, you may contact Care-Line (24 hour crisis hotline) (740) 593-3344.

**Fees**

The fee for an initial session is $110.00 per hour; please allow 60 to 90 minutes for your initial appointment. Ongoing sessions will be billed at $100.00 an hour for a 50 minute psychotherapy session. If you are uninsured the intake fee and regular session fee is $90.00 an hour. All other fees are based on the amount or time involved. Additional services include telephone consultations, and administering, scoring, analyzing and reporting diagnostic assessments. These professional services will be billed at $100.00 per hour in 15minutes increments.

I ask that you pay your fee, deductible, or co-pay as you go. If this payment procedure presents a problem for you then please bring this up so that we can discuss other arrangements.

**Confidentiality**

Your counseling records are confidential and my practice is dedicated to maintaining the privacy of your personal health information. Ohio law mandates that issues addressed during the course of therapy not be discussed with others without your knowledge and expressed consent. Your records will not be sent or shown to others without a signed release from you.

There are exceptions to the protection of confidentiality. Wherein the release of confidential information is or may be required of a therapist. These occur in cases of child, elder, or disabled person abuse or neglect; potential harm to oneself (suicide), potential harm to others (homicide); or in instances where the court may subpoena records and where an agency or institution has mandated counseling.

Insurance and managed care companies generally require a diagnoses before they will pay for therapy. I would be glad to discuss this with you. All of the diagnoses come from a book called the DSM-5 (for psychological diagnoses) or one called the ICD-10-CM (used more for medical diagnoses but often requested by insurance companies. The amount of information requested may vary from company to company, and they too are required to maintain this information confidentially. If you are using your insurance for payment I request your authorization on my billing information form so that I may release sufficient information to answer your insurers questions. If you have any questions about this process please do not hesitate to discuss them with your insurance company or me.

**Martha E. Reynolds-Adkins, Ph.D.**

**Professional Clinical Mental Health Counselor**

**3 W. Stimson Ave Suite 2, Athens OH 45701**

**740-508-2202**

**Adult Intake Form**

Your careful completion of this inventory will help me work with you more effectively. The information you share is confidential. Please answer each item as fully and openly as possible. If certain questions do not apply to you, leave them blank.

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

Last Name First Name M.I. Birth date

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

Address Street City State Zip

Phone number (Cell) \_\_\_\_\_\_\_\_\_\_\_\_ May we leave a message? yes no

(Text) May we leave a message? yes no

E-mail address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we send you e-mail? yes no

**Age:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employed?** yes no

**If yes, # hrs/week \_\_\_\_\_\_\_\_\_\_\_Employed where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Gender:** Male **Ethnicity** Asian Heritage  **Relation. Status**

Female Black/African HeritageSingle

Gender Diverse Latino/HispanicMarried

 Multi-ethnic/multi-racial Separated

 Native American Divorced

 White/Caucasian Partnered  Other committed dating International Person Widowed

– From what country?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

--How long in U.S.? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Live With? Do you think of yourself as:**

Roommate(s) Lesbian,gay, or homosexual Straight/heterosexual

Significant Other Bisexual Something else Don’t know

Family

Alone

Religious/spiritual affiliation? Other important world views?

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

Do you desire to have your religious/spiritual beliefs and values incorporated into the counseling process?

Yes No Not sure

Please briefly explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Ability Differences?**

Physical Challenges Visual Challenges Hearing Challenges

Learning Challenges

What is the nature of your learning challenge? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Other (please describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you checked something above, what is the nature of your challenge? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

List accommodations needed for counseling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Counseling History**

Are you participating in other counseling services now? Yes No

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

Have you participated in counseling before? Yes No

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

Have you ever been diagnosed with a mental health problem? What was the diagnosis?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is (are) your main reason(s) for this visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

How long has this problem persisted?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about this office or who referred you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For weight control I have used: I have in the past: I have currently:**

Vomiting Thought to harm myself Thought to harm myself

Laxatives Tried to harm myself Tried to harm myself

Not eating Thought to harm others Thought to harm others

Diet pills or herbs / supplements Tried to harm persons Tried to harm persons

Extensive exerciseSpecial dietsOther:

**I use alcohol &/or drugs: The following have resulted from my use of alcohol or drugs:**

Never Traffic violations Fight with friends/family

Less than once per week Academic problems Blackouts

About once a week Relationship problems Legal problems

Several times a week Disciplinary job actions Regretted sexual activity

Most every day Financial problems

**I have recently experienced problems with the following:**

Sleeping Depression Guilt Feelings of stress

Appetite Anxiety Feeling worthless Concentration

Fatigue Mood shifts Thoughts of death Social isolation

Difficulty in expressing emotion Feelings of anger  Sexual functioning Shame Organization Weight loss or gain Body Image

Loss of pleasure in most activities

**Have you ever been prescribed medicine for psychological problems? If so, what?**

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

**Please list all current medications you are taking.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any allergies I should know about?**

**Who is your family Dr? When was your most recent physical?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list any trauma you may have experienced (sexual abuse, physical abuse, verbal abuse, life threatening experience, loss of parent as a child)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Person to contact in an emergency and your relationship to this person?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family members and/or other persons important to you: Occupation Relation Age Deceased?**

**Martha E. Reynolds-Adkins, Ph.D.**

**Professional Clinical Mental Health Counselor**

**3 W. Stimson Ave, Suite 2, Athens OH 45701**

**Billing Information Intake**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

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

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Work Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home/Cell Number: \_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you employed? Yes No Gross Annual Income? (optional)\_\_\_\_\_

Name and address of employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have insurance coverage? Yes No

Name and address of the insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group No.: \_\_\_\_\_\_\_\_\_\_

Identification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you covered by a second insurance company? Yes No

Name and address of the insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group No.: \_\_\_\_\_\_\_\_\_

Identification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to this office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In order to secure payment for my treatment through my insurance company, I authorize Martha E. Reynolds-Adkins, Ph.D. to cooperate with my insurance company’s claims and managed care procedures, including sufficient clinical information (for example, diagnosis, symptoms, and treatment plans) to answer their specific questions. I understand the insurance/managed care company is obligated to obtain this information confidentially. I authorize the aforementioned insurance company to make payment directly to Martha E. Reynolds-Adkins, Ph.D. I understand that I am financially responsible for the charges by my insurance and that the entire bill is my responsibility, regardless of my insurance coverage.

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

Signature of Responsible Party (if under 18 years old): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Martha E. Reynolds-Adkins, Ph.D

3 W. Stimson Ave. Suite 2

Athens, Ohio 45701

O:(740) 508-2202 F:(833) 589-1711

NOTICE OF PRIVACY PRACTICES

Notice of Mental Health Counselors’ and Psychologist’ Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

1. PHI refers to information in your health/counseling record that could identify you.

2. Treatment, Payment and Health Care Operations-treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another mental health service provider.

3. Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

4. Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

5. Use applies only to activities within my practice group such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

6. Disclosure applies to activities outside of the practice group, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An authorization is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy notes are notes that I have made about conversations and/or activities during a private, group, joint, or family counseling session, which are kept separate from the rest of your counseling record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances: (note, whenever possible, you will be directly consulted prior to the release of such information.)

1. Child Abuse: If, in my professional capacity, I know or suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, I am required by law to immediately report that knowledge or suspicion to the Ohio Public Children Services Agency, or a municipal or county peace officer.

2. Adult and Domestic Abuse: If I have reasonable cause to believe that an adult is being abused, neglected, or exploited, I am required by law to immediately report such belief to County department of Job and Family Services.

3. Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release the information without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

4. Serious Threat to Health or Safety: If I believe that you pose a clear and substantial risk of imminent serious harm to yourself or any other person, I may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to me an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victim(s), and I believe you have the intent and the ability to carry out the threat, then I am required by law to take one or more of the following actions in a timely manner:

1) take steps to hospitalize you on an emergency basis,

2) establish and undertake a treatment plan calculated to eliminate that possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional,

3) communicate to the law enforcement agency and, if feasible, to the potential victim(s), or victim(s) parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s).

4. Workers Compensation: If you file a workers compensation claim, I may be required to give your mental health information to relevant parties and officials

IV. Patient's Rights and Psychologist/Clinical Counselor’s Duties

Patients Rights:

1. Right to Request Restrictions You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

2. Right to Receive Confidential Communications by Alternative Means and at Alternative Locations You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

3. Right to Inspect and Copy You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

4. Right to Amend You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

5. Right to an Accounting You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.

6. Right to a Paper Copy You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist/Clinical Counselor’s Duties:

1. I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

2. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

3. If I revise my policies and procedures, I will provide a copy of the revision to each client.

V. Questions and Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision that I have made about access to your records, you may contact The Ohio Psychology Board, 775 High Street, 18th floor, Columbus, OH 43266-0321, (614) 466-8808 or the Counselor and Social Worker Board, 65 South Front Street, Suite 210, Columbus, OH 43266, (614)466-0912.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in writing to be delivered to you on our next scheduled appointment.