Barnabas Behavioral Healthcare, LLC

THE PROCESS OF COUNSELING

Counseling is a special, safe, healing, and respectful process wherein a trained helper works with a wounded person to reach a mutually agreed upon goal and level of functioning that reflects psychological wellbeing. We work with a broad variety of individuals with differing life stresses, coping resources and abilities.

The INTAKE is the initial session wherein the client and practitioner meet to understand the presenting concerns and develop a plan to address change. It also allows the assessment of therapeutic good fit and the ability to work together in a mutually responsible manner. This initial stage may be further refined according to circumstances and progress made. Psychological testing may be utilized to understand and define inner dynamics more fully.

Everyone is unique and life circumstances vary widely so the process and length of treatment will differ among clients (even if someone else seems to be undergoing or has experienced similar problems).

The next phase of counseling involves gaining a fuller understanding and taking ownership of the identified problem(s) and the way psychological, relational, and/or medical components work and are addressed and repaired. You will try a personalized treatment strategy with teaching, coaching, and encouragement from your professional helper.

The final stage simply involves fine tuning until you are feeling that you can take it from there (it's OK to need a few follow-ups from time to time).

THE PROCESS OF PSYCHIATRIC CARE

Similar to counseling, the process of psychiatric care also involves a collaborative relationship between the patient and provider. Psychiatric care is individualized for the unique needs of each patient; therefore, it is important to evaluate past medical and psychiatric history and overlay this with current medical and psychiatric presentation. At times, with the patient's consent, this may involve gathering information from other sources, such as family members and other medical providers. Screening tools and/or questionnaires may be utilized to aid diagnosing and gauge patient status. Lab tests are also an important component of some treatment plans, as these assist with tracking medication levels and overall response to treatment.

The goal of psychiatric care is to provide patient-centered, holistic care; therefore, the duration of psychiatric treatment and frequency of follow-up visits depends on multiple factors that are specific to each patient. On average, adult medication management follow-up appointments are initially scheduled at intervals of 3 to 4 weeks. Thereafter, the timeline between follow-up appointments increases to 3 to 4 months and expands from this point, based on the needs of the patient and type(s) of medications being prescribed. Follow-up appointments for pediatric and adolescent patients are typically scheduled at 2-week intervals, followed by 1-month med checks, and then quarterly (every 3 months). For pediatric and adolescent patients, "eyes on" care is an important factor in providing safe, high-quality care. Therefore, for these patients, if medication is prescribed for a mood or behavioral disorder, attending counseling is an important aspect of achieving long-term wellness, life-long coping skills, as well as gauging effectiveness of the current treatment plan.

CONFIDENTIALITY

All communication between you and your counselor will be held in confidence and will not be revealed to anyone, unless required by law. Information that you wish to disclose to or obtain from anyone will only be initiated with your written consent.

OFFICE HOURS AND COMMUNICATION

Our office hours vary among our counseling staff. Limited evening and Saturday morning appointments are available. Staff can typically be contacted at our Evelyn Drive office by calling (803) 216-0850 between 9:00 a.m. and 5:00 p.m., Monday through Friday. You may leave a voicemail if our line is busy or after hours. You may also ask your provider how to contact them on an individual basis.

APPOINTMENTS

Typically, your counselor will schedule to see you weekly during a standing appointment time (your time reserved just for you). However, because you may need to change your appointment from time to time, we ask that you verify your next appointment with your counselor at the end of each session. Changes in appointments can so be made by phone; priority will, however, be given to those with standing appointments.

CANCELLATION OF APPOINTMENTS

You may cancel an appointment without charge by calling 24 hours in advance. Except in cases of emergency, cancellations without sufficient notice will lead to a charge of one-half the normal fee on the first occasion all others will incur a full-fee charge. Patient insurance will not cover a cancellation/"no show" charge and you will be responsible for the balance.
Late cancellations prevent your counselor from being able to schedule this time with other clients in need. Others may request to see your counselor, perhaps in a crisis, and be turned away only to find that the scheduled appointment was missed. Two consecutive cancellations of any kind may also lead to forfeiture of your standing appointment time and the need for you to find a new time.

FEES AND PAYMENTS

We have attempted to set our fees at a reasonable level in accordance with state and national fee schedules. They are moderate in comparison with the prevailing rates in this area. In most situations the client pays only the co-pay amount and/or coinsurance amount and insurance company is billed for the remainder. We expect full payment of your portion at the time of service as well as any account balance you may have incurred from previous appointments.
We will file insurance claims as a courtesy to our clients however it is solely the responsibility of the client to notify us of any insurance changes.
You may use check, cash, and credit card for payment. There is a charge for testing, and costs vary with the individual test or tests taken.
If you are not covered by insurance and you have a limited income, you may request to be a self-pay client and we can discuss sliding scale fees. If you have questions about whether your insurance policy covers counseling services, you need to call your insurance company or agent to determine this. Our office staff is familiar with the coverage on some policies but, frankly, insurance companies can sometimes be unreliable. Since the insurance arrangement is between you and your insurance company the burden is yours to insure proper dispensation. We welcome this opportunity to serve you and look forward to working with you.

In the event of an emergency, if we cannot be reached, please go directly to the emergency room of the hospital of your choice and continue to attempt to contact us. Prisma ER (formerly Palmetto Health) can be reached at (803)-434-4813 or dial 911.

Barnabas Behavioral Healthcare, LLC

Payment & Insurance Information

As a courtesy to our patients, we can file your bill to your insurance company. It's much easier for the both of us if we have the right information up front. If you have questions about how the billing process works, feel free to call or browse through our frequently asked questions page on our website.

A word of protection for our patients:

- Your treatment with us may be covered by a different insurance than a visit with your family doctor.
  You can usually find on the back of your insurance card the mental/behavioral health phone number if you are unsure.
- Some providers may NOT be in network with your insurance company.
  You can contact your insurance company and give them the name of the provider you are wanting to see.

We do our best to schedule your appointment with an In Network provider, however we have found that certain insurances outsource their mental health coverage processing to a completely different company (Blue Cross Plan XYZ may cover a primary care physician office visit while sending mental health claims to United Behavioral Health Plan ABC). The issue with this is while your provider may in fact be In Network with the insurance company named on your card, they may out of network if the claims are sent elsewhere.

In our example above, the provider was not in network because the mental health coverage is with a different company. Most of the time, it is easy for us to determine if this is case and generally there are only a few insurance companies that do this. We strongly recommend that you speak with your insurance company to determine where the mental health (sometimes referred to as behavioral health) coverage is processed. *We will pass on to you what your insurance tells us you owe*. This means that if the insurance company tells us we have the wrong company, the wrong date of birth, the wrong ID etc., or to apply out of network coverage, you will be responsible for the payment according to your coverage.

Please note, some visits will require an authorization and/referral. We know that Humana will require your primary care physician to send us a referral to treat you. Some psychological testing may require approval prior to your visit.

Please fill out the areas below as accurately as possible:

EMAIL or Fax or Send or Bring a copy of your insurance card(s)
Email- appointments@barnabashealthcare.com
Fax- 803.216.0420

Patient Name: _____ Patient Date of Birth: _____
Primary Insurance: _____ Patient SSN: _____
Insurance ID: _____
Insured By: _____ Relationship to Insured: ___ Self
Insured by Date of Birth: _____ ___ Spouse
Insurance Address: _____ ___ Child
Mental Health Phone: _____ ___ Other:

Secondary Insurance: _____
Insurance ID: _____
Insured By: _____ Relationship to Insured: ___ Self
Insured by Date of Birth: _____ ___ Spouse
Insurance Address: _____ ___ Child
Mental Health Phone: _____ ___ Other:

AUTHORIZATION FOR PAYMENT

For convenience, we offer different payment options. You can call us after your visit to pay over the phone, pay through the patient portal or we can store a credit card on file for you. If you have any questions about your balance, feel free to call our billing team or send a message through the portal. We will not schedule follow up visits with an outstanding patient balance. Standing appointments require a zero balance weekly or to have a card on file for payment. If you would like to setup a card on file, please fill out the following information. If you chose to place a maximum debit amount and have any questions regarding what your portion of your bill will be (self pay or insurance), we are happy to help.

Please select from the following payment options.

____ I will make my payments by mail
____ I will make my payments through the patient portal
____ I will make my payments over the phone with a credit card
____ I will make my payments in person with cash/check/credit card
____ I will make my payments with the following card on file.

Card on File for Payment Information

Card Number: _____ Type of Card: _____
Name on Card: _____ Expiration Date: _____
Billing Address: _____ CITY/STATE/ZIP: _____
_____ CVV: _____

Please indicate your preference.

INITIALS ___I give permission to Barnabas Behavioral Healthcare, LLC to bill my credit card on file

___I give permission for a monthly payment

___I give permission for a biweekly payment

___I give permission for a weekly payment

INITIALS ___Debit my account for patient responsibility balance

___Full Balance

___Up to Maximum Debited $_____

_____ _____
Signature Date

Patient Care Communication Form

(release of information to Primary Care Provider)

Primary Doctor/Care Provider/Referring Doctor's Name _____

Telephone _____ Fax _____

Address _____ City _____ State _____ Zip _____

Dear _____ ,

Your patient, _____ has been seen by _____ .

Date of initial assessment _____ . Next appointment _____ .

Diagnosis and or presenting problem _____

Treatment recommendations _____

Medication Issues _____

Please call if further information or clarification would be helpful,

Sincerely,

_____

Authorization to Disclose Information

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this content at any time except to the extent that action has been taken in reliance on it. This release will expire 12 months after first signed.

_____ I want this information released to my Primary Doctor/Provider/Referring Doctor

_____ I DO NOT want this information released to my Primary Doctor/Provider/Referring Doctor

Patient _____ Date _____

Parent/Guardian _____ Date _____

Witness _____ Date _____

Acknowledgement of Receipt of Privacy Practices

I have read, understood, and received a copy of Barnabas Behavioral Healthcare LLC Notice of Privacy Practices and a copy of this form will be retained in my medical chart.

Signed:_____Date: _____

Printed Name: _____

Barnabas Behavioral Healthcare, LLC

Specializing in the Strategic Integration of Behavioral and Medical Care

Glenn P Zaepfel, Ph.D. | David C Jones, FNP-BC | Thomas E Cromer, LISW-CP
Linda C Zaepfel, APRN-BC, LISW-CP | Laura J Miller, LICSW-CP, MAC, CACII | Rachel Lewis, LISW-CP
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The following form will become part of your confidential record. Please answer each question as carefully as you can. You may use the back of any page for additional comments

Date _____ Name _____ Date of Birth _____ Age _____ Sex _____

Present address _____

Telephone Home _____ Work _____ Mobile _____

Social Security Number _____ EMAIL _____

Emergency Contact _____

Their address _____

Their phone _____

Marital status _____ If married, number of years____ Number of Marriages ____

If separated/divorced, how long? _____

Living with: Spouse ____ Roommate ____ Alone____ Parents____ Children ____

Occupation _____ Hours per week _____

Employer _____

Highest Level of education completed _____ Major _____

Religious Affiliation _____ Number of times you attend religious services per month _____

Explain your spiritual beliefs _____

Name of primary care provider (M.D., N.P., or P.A.) _____

Address _____ Phone _____

Are you currently receiving medical treatment? Yes ____ No ____ Please describe any problems you have that require medical or physical care _____

Have you previously had counseling/therapy? Yes ____ No ____ When? _____ How long? _____ With whom? _____

Why did you stop? _____

Do you use or have you used any of the following (how much, how often, and for how long?

Cigarettes _____

Alcohol _____ Family Members _____

Other Substances _____ Family Members _____

List any family history of mental illness _____

List any drug or food allergies you may have _____

FAMILY MEMBERS

	Name	Age	Occupation or grade in school
Spouse			
Children			
Stepchildren			
Father			
Mother			
Siblings			

Problem Areas: In the following list, please place a check next to each item which indicates an area of concern to you. Please place two checks by items which are most important (you may add comments.)

_____ Anxiety
_____ Depressed mood
_____ Guilt feelings
_____ Over activity
_____ Weight loss
_____ Weight gain
_____ Headaches
_____ Feelings of inferiority
_____ Loss of interest
_____ Poor sleeping
_____ Repetitive ideas
_____ Thought of suicide
_____ Wish to hurt others
_____ Marital relationship
_____ Financial problems
_____ Lonely/too few friends
_____ Unhappy most of the time
_____ Problem with children
_____ Troubling memories
_____ Inability to relax
_____ Memory difficulties
_____ Lack of confidence
_____ Can't make decisions
_____ Bitterness or resentment
_____ Periods of over activity
_____ Eating problems
_____ Shy or awkward with others

_____ Unable to trust others
_____ Change in eating habits
_____ Fighting/arguing with others
_____ Can't stand up for myself
_____ Can't say "no" to others
_____ Poor adjustment to job/school
_____ Bad temper/anger problems
_____ Difficulties with opposite sex
_____ Stomach or bowel disturbance
_____ Unfairly treated by others
_____ Repetitive behaviors
_____ Drinking or drug problems
_____ Rely too much on others
_____ Suspicious of others
_____ Recent loss of someone
_____ Sexual problems/concerns
_____ Family quarreling
_____ Fearful of things or situations
_____ Religious/spiritual concerns
_____ Cardiovascular /heart problems
_____ Alcohol/drug problem in family
_____ Unusual/strange experiences
_____ Stress from recent event
_____ Divorce/separation difficulty
_____ Troubling habits/thoughts
_____ Feeling rejected by family
_____ Other (specify)

In your own words, briefly describe the main problem(s) which prompted you to seek help at this time.

_____

_____

_____

Have there been times when the problem(s) got better or disappeared? Yes_____No_____

If so, when_____

_____

What do you think helped?_____

_____

Were there times when the problem was especially bad? Yes_____ No_____ If so, when? _____

What made it bad? _____

_____

Are there other people who play a role in causing your problem? _____

Helping your problem?_____ Explain briefly_____

_____

_____

Name the main goal that you would like to reach in counseling _____

_____

_____

_____

How did you hear about our center? _____

_____

I completed the above information accurately and have read and agree to the general information and policy statements of Barnabas Medical-Behavioral Healthcare, LLC. I give my consent for services with Barnabas Medical-Behavioral Healthcare and its professional staff to include assessment, diagnosis, psychotherapy, pharmacotherapy, involvement in the treatment planning process, evaluation and testing as appropriate.

Signature _____ Date _____

Provider _____ Date _____

Medical History

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

Patient Medical History

- ☐ Headache
- ☐ Shortness of Breath
- ☐ Heart Palpitations
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Dizziness/Fainting
- ☐ Peripheral Vascular Disease
- ☐ Allergies/Hay fever
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Ulcer
- ☐ GI Disorder
- ☐ Lactose Intolerance
- ☐ Gallbladder Disease
- ☐ Prostate Problems
- ☐ Bowel Irregularity
- ☐ Incontinence
- ☐ Overactive Bladder
- ☐ Frequent Urination
- ☐ Sexual/Menstrual Dysfunction
- ☐ Venereal Disease
- ☐ Frequent Infections
- ☐ Hepatitis
- ☐ Anemia
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Nervousness
- ☐ Depression
- ☐ Gout
- ☐ Scarlet fever
- ☐ Chronic rashes
- ☐ Rheumatic fever
- ☐ Mumps
- ☐ Measles
- ☐ Rubella
- ☐ Polio
- ☐ Diphtheria
- ☐ Tetanus

Date _____ Patient DOB _____

Patient Name _____ Patient Signature _____

Provider _____ Parent/Guardian Signature _____

Please CLEARLY list any current medications you are taking	**Strength**	**Dose**	**Frequency**
Example- Zithromax Z-Pack	*250 mg*	*2 Pills*	*Daily*

Please list clearly any allergies as it related to medications

Example -Penicillin

Preferred Pharmacy Name

Phone Number _____

Address _____

Primary Care Doctor _____ Fax Number _____

Referring Provider _____ Fax Number _____

PATIENT HEALTH QUESTIONAIRE (PHQ-9)

Name: _____ Date: _____

Over the last 2 ***weeks***, how often have you been bothered by any of the following problems?

(use a "✓" to indicate your answer)

		Not at all	Several days	More than half of the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself- or that you are failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		Add Columns		+	+
	TOTAL				
10.	If you have checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all Somewhat difficult Very difficult Extremely difficult			

The Mood Disorder Questionnaire

Name: _____ Date: _____

Instructions: Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	Yes	No
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	◯	◯
...you were so irritable that you shouted at people or started fights or arguments?	◯	◯
...you felt much more self-confident than usual?	◯	◯
...you got much less sleep than usual and found you didn't really miss it?	◯	◯
...you were much more talkative or spoke much faster than usual?	◯	◯
...thoughts raced through your head or you couldn't slow your mind down?	◯	◯
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	◯	◯
...you had much more energy than usual?	◯	◯
...you were much more active or did many more things than usual?	◯	◯
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	◯	◯
...you were much more interested in sex than usual?	◯	◯
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	◯	◯
...spending money got you or your family into trouble?	◯	◯
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	◯	◯

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please select one response only.

◯ No Problem ◯ Minor Problem ◯ Moderate Problem ◯ Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness " " or bipolar disorder?	◯	◯

Generalized Anxiety Disorder Questionnaire (GAD-7)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Feeling nervous, anxious or on edge?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
2. Not being able to stop or control worrying?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
3. Worrying too much about different things?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
4. Trouble relaxing?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
5. Being so restless that it is hard to sit still?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
6. Becoming easily annoyed or irritable?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
7. Feeling afraid as if something awful might happen?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

The GAD-7 score is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of 'not at all', 'several days', 'more than half the days', and 'nearly every day', respectively, and adding together the scores for the seven questions.

0 Points	Not at all
1 Point	Several days
2 Points	More than half the days
3 Points	Nearly every day

TOTAL SCORE

_____

Patient Name: _____/ Date: _____

BARKLEY'S Quick-Check for Adult ADHD Diagnosis Modified

Please answer the following questions by placing a check mark under the corresponding column yes or no.

Current ADHD Symptoms			
Do you…?			
1.	Made decisions impulsively?	YES	NO
2.	Have difficulty stopping activities or behavior when you should do so?		
3.	Start projects or tasks without reading or listening to directions carefully?		
4.	Have poor follow through on promises?		
5.	Have trouble doing things in proper order?		
6.	Drive with excessive speed?		
7.	Often become easily distracted by extraneous stimuli?		
8.	Often have difficulty sustaining attention in tasks or leisure activities?		
9.	Often have difficulty organizing tasks and activities?		
	Total check marks for each column		

Areas of Impairment			
Do you feel that your symptoms impair your…?			
1.	Occupation or job?	YES	NO
2.	Social life?		
3.	Educational activities?		
4.	Family Life?		
	Total check marks for each column		

Recall of Childhood Behavior			
When you were a child, did you…?			
1.	Often fail to give close attention to details or make careless mistakes in your work?	YES	NO
2.	Often have difficulty sustaining attention in tasks or fun activities?		
3.	Often feel restless?		
4.	Often avoid, dislike, or were reluctant to engage in work that required sustained mental effort?		
5.	Often forget things in your daily activities?		
6.	Often interrupt or intrude on others?		
	Total check marks for each column		

Patient Name: _____ /Date:_____

Adult Self-Reported Survey

	Please answer the following questions by marking the corresponding frequency as each question applies to you.	Never	Rarely	Sometimes	Often	Very Often
1.	How often do you have trouble wrapping up the final details of a project once the challenging parts have been done?					
2.	How often do you have difficulty getting things in order when you must do a task that requires organization?					
3.	How often do you have problems remembering appointments or obligations?					
4.	When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5.	How often do you fidget or squirm with your hands or feet when you must sit down for a long time?					
6.	How often do you feel overly active and compelled to do things, like you were driven by a motor?					
	Total Shaded Responses Questions 1-6	Total_____				
7.	How often do you make careless mistakes when you must work on a boring or difficult project?					
8.	How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9.	How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10.	How often do you misplace or have difficulty finding things at home or at work?					
11.	How often are you distracted by activity or noise around you?					
12.	How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13.	How often do you feel restless or fidgety?					
14.	How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15.	How often do you find yourself talking too much when you are in social situations?					
16.	When you are in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish?					
17.	How often do you have difficulty waiting your turn in situations when turn taking is required?					
18.	How often do you interrupt others when they are busy?					

Barnabas Behavioral Healthcare LLC

Notice of Privacy Practices

This notice describes how medical, drug and alcohol and psychological related information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

General Information

Information regarding your health care, including payment for health care, is protected by two federal laws; the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320det seq,, 45 C.F.R. Part 160 & 164 and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2. Under these laws, Barnabas Behavioral Healthcare LLC may not say to a person outside Barnabas Behavioral Healthcare LLC that you attend the practice, nor may Barnabas Behavioral Healthcare LLC disclose any information identifying you as a client, or disclose any other protected information except as permitted by federal law.

Barnabas Behavioral Healthcare LLC must obtain your written consent before it can disclose information about you for payment purposes. For example, Barnabas Behavioral Healthcare LLC must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before Barnabas Behavioral Healthcare LLC can share information for treatment purposes or for health care operations. However, federal law permits Barnabas Behavioral Healthcare LLC to disclose information without your written permission in the following situations:

1. Pursuant to an agreement with a qualified service organization/ business associate
2. For research, audit or evaluations.
3. To report a crime committed on Barnabas Behavioral Healthcare LLC premises or against Barnabas Behavioral Healthcare LLC personnel.
4. To medical personnel in a medical emergency.
5. To appropriate authorities to report suspected child abuse or neglect or domestic violence.
6. As allowed by a court order.

For example, Barnabas Behavioral Healthcare LLC can disclose information without your consent to obtain legal or financial services, or to another medical facility to provide health care to you, as long as there is a qualified services organization/ business associate agreement in place.

Barnabas Behavioral Healthcare LLC may need to share your protected health information with third party "business associates" that perform various activities such as laboratory services and billing partners. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Before Barnabas Behavioral Healthcare LLC can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing at any time.

Your Rights:

Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health information. At your request, Barnabas Behavioral Healthcare LLC will not disclose information to your health insurance plan about any services for which you have paid out-of-pocket.

Barnabas Behavioral Healthcare LLC is not required to agree to any other restrictions you request, but if it does agree, then it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.

You have the right to request that we communicate with you by alternative means or at an alternative location. Barnabas Behavioral Healthcare LLC will accommodate such requests that are reasonable and will not request an explanation from you. Under HIPAA you also have the right to inspect and copy your own health information maintained by Barnabas Behavioral Healthcare LLC, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.

Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in Barnabas Behavioral Healthcare LLC records, and to request and receive an accounting of disclosures of your health related information made by Barnabas Behavioral Healthcare LLC during the six years prior to your request. You also have the right to receive a paper copy of this notice.

Barnabas Behavioral Healthcare LLC Duties:

Barnabas Behavioral Healthcare LLC will not share your protected health information for marketing or fundraising purposes, nor will we ever sell your protected health information without your prior approval.

Barnabas Behavioral Healthcare LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. Barnabas Behavioral Healthcare LLC is required by law to abide by the terms of this notice. Barnabas Behavioral Healthcare LLC reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. You may access a revised version by accessing our website, or you may request a copy by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, please contact our Compliance Officer Thomas Cromer at 803-216-0850.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations. You may complain to us using the contact information listed at the end of this Notice. You also may submit a written compliant to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer. The contact information is provided below.

Contact Officer: Thomas Cromer, Corporate Compliance Officer Telephone: 803-216-0850 Fax: 602-253-6554

Address: 409 Evelyn Drive Columbia, South Carolina 29210