Behavior Assessment

Name _____ **Date** _____

Check the behaviors listed below that apply to your child within the past 6 months

___ Appears depressed or sad most of the day
___ Irritable mood most of the day
___ Diminished pleasure in all or almost all activities
___ Appears lethargic or restless
___ Significant weight change
___ Sleep problems almost every night
___ Reports fatigue or loss of energy nearly every day
___ Reports feeling hopeless or excessively guilty
___ Inability to concentrate or to make decisions
___ Thoughts about death or "I wish I were dead" comments
___ Isolates from friends

___ Is using drugs, I suspect
___ Is using drugs, I know because_____
___ Engages in self-destructive behaviors:
___ hair pulling___ self-biting_____ self-pinching_____ head banging
___ cutting Other: _____

___ Abnormally elevated mood nearly every day for a specific period of time
___ Marked elevated mood for at least 4 days
___ Irritable mood
___ Inflated self esteem or grandiosity "I am the king of the world"
___ Very talkative with fast, pressured speech
___ Racing thoughts, changing from topic to topic frequently in conversation

___ Easily distracted or drawn to insignificant stimuli
___ Excessive involvement in activities with painful consequences
___ Decreased need for sleep
___ Daily functioning is impaired or suffers as a result of behaviors
___ Has difficulty sustaining attention
___ Is not detail oriented, makes careless mistakes
___ Does not seem to listen when spoken to
___ Does not follow through on instructions and work
___ Has difficulty organizing
___ Is reluctant to engage in tasks that require sustained mental effort
___ Is easily distracted
___ Is often forgetful

___ Often fidgets
___ Often leaves seat
___ Runs or climbs excessively
___ Has difficulty playing quietly
___ Talks excessively
___ Appears to be "driven by a motor" always "on the go"
___ Blurts out answers or asks questions before directions are given
___ Has difficulty awaiting turn
___ Interrupts or intrudes on others often

___ The above behaviors on this page have been present for at least 6 months
___ The above behaviors were present before the age of 7
___ The behaviors significantly interfere with academic or social functioning

___ Has recurrent or persistent thoughts, impulses, or images that are intrusive and cause distress
___ These thoughts are excessive or "too much"
___ Attempts to ignore or suppress thoughts
___ Recognizes these thoughts are "not right"
___ Repetitive behaviors (hand washing, checking, flicking switches)
___ These behaviors are perceived to reduce tension, to avoid something "bad from happening"
___ These thoughts or behaviors cause marked distress

___ Has developed an emotional or a behavior problem in response to something bad that happened recently in the last 6 months_____
___ We have recently had a death in the family _____
___ Unreasonable fears (heights, animals, the dark, etc.) Please specify: _____
_____
___ Excessive worry about many different things and people
___ Has panic attacks
___ Does not like to be separated from primary caregivers
___ Sleeps in parent(s) room or bed frequently

___Does not have a good body image (Thinks (s)he's fat)
___Counts calories daily
___ Vomits food daily or refuses to eat
___ Excessive exercising to lose weight

___ Bullies or threatens others
___ Initiates fights
___ Has used a weapon which caused harm to others _____
___ Has been cruel to people
___ Has been physically abusive to animals
___ Has stolen or robbed someone
___ Has forced someone to do something against their will
___ Fire setting
___ Deliberately destroyed property
___ Has unlawfully entered into a house, building, or car
___ Is manipulative and lies to get avoid obligations
___ Steals
___ Stays out all night despite parental prohibition before age 13
___ Runs away

___Is truant from school or refuses to attend
___ Poor grades
___ Frequently skips classes
___ Takes Risks
___ Does not observe curfew
___ Destroys property
___ Has been arrested
___ Is sexually promiscuous

___ Frequently lying
___ Frequently talks back
___ Frequently cusses
___ Rarely obeys
___ Physically abusive towards_____
___ Talks back to authority figures
___ Negative comments to:
___ Parents ___ Siblings ___ Peers ___ Others
___ Teasing of:
Teasing of:
___ Parents ___ Siblings ___ Peers ___ Others

___ Has tantrums frequently
___ Cries, whines, or pouts frequently
___Frequently complains or is whiny
___ Will not play alone
___ Problems at mealtimes (disruptive, selective about foods).
___ Is toilet trained but: __ wet pants, __ soils pants, __ wets bed.
___ Seems to have a hearing problem.
___ Seems to have a vision problem.
___ Other physical challenge (specify: _____).
___ Wanders off
___ Has behavior problems:_____
___ Has learning disabilities_____
___ Seldom makes eye contact
___ Was slow in developing speech.
___ Repeats words over and over
___ Demands too much attention
___ Is often sluggish or slow moving in the morning
___ Often has physical complaints (i.e., headaches, stomachaches, etc.)
___ Usually plays alone
___ Asks for help when it is not needed
___ Gives up easily
___ Poor frustration tolerance
___ Does not interact appropriately with:
_____Parents_____ Siblings_____ Peers_____Others
___Poor social skills, does not play well with others
___ Does not engage in independent play
___ Reacts poorly when losing a game.

Please describe other problems: _____

_____

_____

What behavior distresses you the most? _____

_____

_____

What do you think are your child's greatest strengths? _____

_____

_____

Please describe the changes you hope to see in your child as a result of our work:

_____

_____

_____

_____

_____

_____

_____

_____

Child and Family Information Packet

Child's Name: _____ **Date:** _____
Gender: **M** **F** **Age:** _____
Telephone #: _____ **Cell Phone #:** _____
Address: _____ **Child's birth date** _____
City: _____ **Zip code:** _____

If this is not the address you want correspondences sent to, indicate here _____
Your email address _____
Referred by _____
This questionnaire is being completed by _____
Pediatrician name and phone number _____
Past psychiatric counseling or hospitalizations? /With whom and when?
_____
_____
Current medications: _____
Previous diagnosis: _____

Presenting problems: _____
_____

Child Demographics

Child's full legal name: _____ Ht:____ Wt:____
Current school/city: _____ Grade _____
How many times have you moved during your child's lifetime?: _____

Parent Demographics

Mother's name: _____ Age: _____
Your name (if different from above) _____ Age: _____
Please circle your relationship: Biological Adoptive Stepmother Other
Does the child live with you? _____ Yes _____ No
If no, what is your address? _____
Your employer: _____ Are you the insurance holder? _____
Occupation: _____ Hours: _____ Wk Phone #: _____
Currently married to: _____

Father's name: _____ Age: _____
Please circle your relationship: Biological Adoptive Stepfather Other
Does the child live with you? _____ No _____ Yes
Currently married to: _____
Your employer: _____ Are you the insurance holder? _____
Occupation: _____ Work Phone number: _____
Home phone number: _____
If the father's address is different than the child's, please write the address here:

_____

Emergency Contacts

Emergency contact (other than self) _____
Telephone number: _____ Relationship: _____
Do you provide consent for your therapist to release your child to or contact this person in a situation perceived to be an emergency? _____ No _____ Yes

Family and Home Information

List all persons currently living in the primary household:

Name	Age/ Relationship	Sex	Education level	Degree

Natural parents or siblings who do not live in the household:

Name	Age/ Relationship	Sex	Education level	Degree

Custody and Visitation

If you are divorced or separated, please complete

Status of biological parents relationship: _____
Who has legal custody and primary residence? _____
What is the visitation agreement: _____
How long has the child lived at the primary residence? _____
Are you planning to be involved in court proceedings during treatment? _____

Past Treatment

- Has any child received counseling or other forms of help? ___No ___Yes

If "yes," please state with whom and when: _____

_____

- Has your child ever been to an inpatient psychiatric hospital? ___ No __Yes
- Has your child attended a day treatment (PHP) program? ___ No __Yes
- Have you filed any complaints against any past therapist? ___No __Yes
- Do any of the other children have difficulties? ___ No __Yes

  If "yes," please explain: _____

  _____

- **Did the therapy help you and your child?** _____

Family Medical History

Is there a **confirmed or suspected** history of any of the following in the family?

M= Mother / F=Father / GF=Child's Grandfather / GM= Child's Grandmother/ A= Child's Aunt / U= Child's Uncle

_____	Drugs	_____	Convulsions/seizures
_____	Alcohol	_____	Goiter (Thyroid)
_____	Depression	_____	Vision problems
_____	Anxiety	_____	Hearing Problems
_____	Bipolar	_____	Schizophrenia
_____	Mental retardation	_____	Suicide attempt

Is there a history of other conditions, not listed above? (Please explain) _____

_____

_____

_____

Domestic Violence

Is your house troubled by domestic violence? ___No ___ Yes

Has the child witnessed or been a victim of domestic violence? ___No ___ Yes

Does your child have a history of sexual or physical abuse?___No ___ Yes

If "yes," please explain: _____

_____

Drugs/Alcohol

If any family member has a past or present alcohol or drug problem, please explain the extent, treatment (if any), and exposure to the child:

_____

_____

Older Child

Do you suspect your child has tried or is using drugs or alcohol? No___Yes___

Do you suspect your child has tried or is smoking cigarettes? No___Yes___

Do you suspect your child is sexually active? No___Yes___

All Ages

Do you suspect your child has an eating disorder? No___Yes___

Does your child have frequent somatic complaints? No___Yes___
(headaches, stomachaches, vague symptoms)?

Does your child have problems getting along with other children? No__Yes___

Does your child have any friends? No___ Yes___

Is your child independent? No___Yes___

What are your child's predominant moods? _____

(Please circle)

Does your child: Eat fine Overeat Under eat

Does your child: Sleep well Sleep too much Problems falling asleep
Night time or early morning awakenings

Does your child sleep: In his/her own room With Mom/Dad frequently

Medication History

Date	Age	Drug	Reason	Physician
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Medical Conditions:_____

Detail all hospitalizations and surgeries:

_____

_____

Child's Developmental and Medical History

Were there any prenatal problems during pregnancy? _____ No ____Yes

If "yes," please explain:

_____

_____

Were there any problems during delivery? (injury, unconsciousness, seizures, surgery)
If "yes," please explain: _____

_____

Birth weight: _____ lbs _____ oz.

Infancy

- Were there any feeding problems? _____ No _____Yes
  If "yes," please explain: _____

  _____
- Did your child sleep well? _____No _____Yes
  If "no," please explain: _____

  _____
- What was your child's temperament as a baby?

  _____
- **Has your child ever had any seizures?** _____

_____

Milestones

At what age did your child:
Wean _____ Walk _____ Sit up alone ____ Talk ____ Toilet trained_____
Were there any difficulties? _____
Were any of the above milestones delayed or advanced? _____

Are there any current problems with bedwetting/accidents? __No __Yes

_____ Night _____ Frequency
_____ Daytime accidents _____ Frequency

Please indicate age of child at the time of illness:

_____	Chickenpox	_____	Mumps
_____	Diphtheria	_____	German measles
_____	Red measles	_____	Poliomyelitis
_____	Rheumatic fever	_____	Scarlet fever
_____	Tuberculosis	_____	Whooping cough
_____	Pneumonia	_____	Other

If other, please explain_____

Does or did your child ever have severe ear infections? _____No _____Yes
Does or did your child have shunts? _____No _____Yes
Does or did your child have allergies? _____ No _____Yes
If "yes," to what does the child have allergies? _____

How severe are the reactions? _____

Are there any special precautions that need to be taken? _____

_____

Does or did your child have lead poisoning? _____No _____Yes

School History

Is your child receiving accommodations at the school? _____

What are the accommodations? _____

Is your child under a 504 or Special Education program? _____

	Date	Location	Problems (Y/N)	Reason for leaving
Preschool				
Kindergarten				
Grade 1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

If answered "yes," to problems at any academic level, please detail here. Please give any information about treatment (if any) provided by the school at the time of occurrence:

_____

_____

_____

Please indicate if there is anything significant that the therapist should be aware of that was not already asked in this questionnaire:

_____

_____

Thank you for taking the time to complete these questions. The therapist really does need all of this information to provide the best care and treatment plan for you and your child.

HIPAA NOTICE OF PRIVACY PRACTICES

I. 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.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office and on my website . You may also request a copy of this Notice from me, or you can view a copy of it in my office or on my website. This policy went into effect April 15, 2003.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

Primary Uses and Disclosures of Protected Health Information (Do Not Require Your Consent)

I may use and disclose your PHI without your consent for the following reasons:

1. For treatment. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or

in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

5. Business Associates

We may contract with individuals and entities (called Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide service support, utilization management, subrogation. Examples of our business associates would your insurance company, consulting professionals, the law firm and CPA who complete required reports to the state, etc, the individual who completes billing functions (Quickbooks) and secretarial appointment reminders.

6. Other Covered Entities

We may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and we may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that we may disclose or share your PHI with other insurance carriers in order to coordinate benefits if you or your family members have coverage through another carrier.

Potential Impact of State Law

The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

Other Possible Uses and Disclosures of Protected Health Information Without your Consent

The following is a description of other possible ways in which we may, and are permitted to, use and/or disclose your PHI without your consent:

- **Required by Law**

We may use or disclose your PHI to the extent that other laws require the use or disclosure such as state, federal, local law, judicial board, law enforcement, or government agencies.
When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule.
For example, we may disclose your PHI when required by national security laws or public health disclosure laws, a search warrant, or pursuant to the Texas health and Safety Codes. This includes disclosing information in the interest of National Security. This also includes subpoenas for court testimony and an arbitrator who compels disclosure.

- **Public Health Activities**

We may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability. We also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Secretary of the US Department of Health and Human Services, Texas Board of Professional Examiners (or other licensing agency) and all Certifying Agencies.**

We may disclose your PHI if the licensing or certifying boards of your therapist's credentials or the US Department of Health and Human Services is investigation or determining our compliance with the HIPAA Privacy Rule.

- **Health Oversight Activities**

We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (1) the health care system; (2) government benefit programs; (3) other government regulatory programs; and (4) compliance with civil rights laws.

• Abuse or Neglect

We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence as is mandated by the Texas Child Abuse and Reporting Law. Additionally, as required by law, we may disclose your PHI to a governmental entity authorized to receive such information if we believe that you have been a victim of abuse, neglect, or domestic violence, such as Florida Elder Adult Abuse Reporting Law.

• Legal Proceedings

We may disclose your PHI: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your PHI in response to a court order for such information, but limited to the minimum amount of PHI necessary to comply with the terms of the order.

• Law Enforcement

Under certain conditions, we also may disclose your PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person, or (3) it is necessary to provide evidence of a crime that occurred on our premises.

• Research

For example, if data is compiled for a research project. However, the information would be used to compile data, information that identifies you such as your name and address or date of birth will be withheld.

• To Prevent a Serious Threat to Health or Safety

Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

• Military Activity and National Security, Protective Services

Under certain conditions, we may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

• Workers' Compensation or Disability

We may disclose your PHI to comply with Workers' Compensation laws, requests for mental health disability, and other similar programs that provide benefits for work-related injuries or metal health illnesses.

• Others Involved in Your Health Care

Using our best judgment, we may make your PHI known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to disclosures of your PHI to a family member or close friend, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

Uses and Disclosures of which You to Have the Opportunity to Object.

Disclosures to family, friends, or others.

I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

Other Uses and Disclosures of Your Protected Health Information
Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that we already have used

An appointed representative
We will disclose your PHI to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law.
Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (2) treating such person as your personal representative could endanger you; or (3) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

Disclosures to You
We are required to disclose to you most of your PHI in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your PHI that are for reasons other than treatment, payment and health care operations and are not disclosed through a signed authorization.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

Right to Inspect and Copy
You have the right to inspect and copy your PHI that is contained in a "designated record set." Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set. To inspect and copy your PHI that is contained in a designated record set, you must complete the form entitled "Request for Health Information." This form is available from your therapist. You will receive a response from me within 30 days of my receiving your written request. You will be charged a reasonable fee if you request a copy of your records. We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact us at the number/address provided in this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be able to be reviewed. If this event occurs, we will inform you in our denial that the decision is not able to be reviewed.

The Right to Request Limits on Uses and Disclosures of Your PHI.
You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

The Right to Choose How I Send Your PHI to You.
It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). You are required to complete the form "Request for Specific Mode of

Communication" available from your therapist. I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.

The Right to Get a List of the Disclosures I Have Made.
You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

The Right to Amend Your PHI.
If you believe that your PHI is incorrect or incomplete, you may request that we amend our information. You may request that we amend your information by completing the form entitled "Request for Amendment of Health Information." This form is from your therapist. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

The Right to Get This Notice by Email.
You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. Complaints

You may file a complaint if you believe that we have violated your privacy rights. You may file a complaint by contacting:

Audra Boxma
Privacy Officer
OC Building 11983 Tamiami Trail N
Suite #111 & #114 Naples FL 34110
(239) 963-7274

You may also send a written complaint to:

The US Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Complaints filed with the US Department must be made within 180 days of the time you became aware of the problem, be in writing, contain the name of the entity against with the complaint is lodged, and describe the relevant problems. You will not be penalized or retaliated against in any way for filing a complaint.

I acknowledge receipt of this notice. I have read and understand all 6 pages.

Patient Name: _____ Date: _____ Signature: _____

Witness: _____ Date: _____ Signature: _____

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

Patient Name _____

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as "health care operations."). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the office. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Witness Date

Authorization for Release of Information

I, _____, the parent or legal guardian of_____

dob _____ address_____ hereby grant permission to: Audra Boxma LMHC, NCC, CCMHC, CART to ____receive from ____release to:

_____

_____ all verbal and/or _____all written information concerning the past and present medical and mental health status and treatment of the above named child.
The purpose of this disclosure is:

_____ Obtaining information for assessment or treatment

_____ Insurance or other third party reimbursement

_____ Continuity of care

Restrictions of disclosure (if any)

_____

I may revoke this consent at any time by requesting revocation in writing and giving it to my therapist at the Center for ADHD, Behavior Change, and Social Success. I understand revocation does not pertain to previously made disclosures. This release is valid for 12 months from the date of the signature. The therapist shall not condition treatment upon client/legal parent signing this authorization. I have the right to refuse to sign this release of information. I have a right to receive a copy of this form. I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by the HIPAA privacy rule. I understand that if this release is faxed, confidentiality may be compromised. I understand I can prevent this release from being faxed by printing the words "Mail Only" on this line here _____.

Signature: _____ Date: _____

Witness: _____ Date: _____

Minor : _____ Date: _____