Phoenix Center for Health & Mental Wellness, LLC
222 Philadelphia Pike, Ste. 4 Wilmington, DE 19809
Phone: 1- 302-543-5321 Fax: 1- 888-801-2676

Demographic Face Sheet

(All Fields highlighted must be completed by the patient, if not applicable please enter N/A)

***Admission Date**: ____/_____/_____ **(This is the date entered into the program)**

***Patient Full Name**_____

***DOB**_____ /_____/ _____ **Sex:** ◉ M ○ F ○ O

***Address**: _____
(Last know address or information stated on identification card)

***City**_____ **State**_____ **Zip Code**: _____

Email address_____

***Telephone number**_____ ***Cell Phone number**_____

***Primary Language**: _____

***Emergency Contact**_____
(This person must be listed on the Release of Information for Emergency contact & Information)

Phone number_____ **Relationship to Patient** _____

***Primary Care Provider**_____ **Phone number** _____

***Address**: _____

☐ **I *DO NOT* have a Primary Care Provider.**

***Are you on any medications?** ◉ Y ○ N ○ N/A

If yes, please reference the client's medication log, as this information is the most accurate list as of the date of admission.

***Do you have any health problems that we should know about circle?** ◉ Y ○ N ○ N/A
Please Describe_____

***Do you have any allergies to medication?** ◉ Y ○ N ○ N/A
If yes, please list here:

***Do you have any seasonal allergies?** ○ Y ◉ N ○ N/A
If yes, please list here:

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Demographic Face Sheet

(All Fields labeled with * must be completed by the patient, if not applicable please enter N/A)

Insurance Information Please Answer All Questions

Name of Insured_____ **Birth Date of Insured**_____
(This is the name of the person carrying the insurance plan)

Relationship to Patient _____

ID#_____Group#_____

Name of Insurance Company_____

Other insurance Coverage?

Ins. Name_____

Name of insured: _____

Birth Date of Insured _____/_____/_____

Insurance ID#_____

By signing below, you are giving Phoenix Center for Health and Wellness, LLC permission to bill your insurance company for services. You are also giving Phoenix Center for Health and Wellness, LLC permission to release information necessary to bill insurance company. Phoenix Center for Health and Wellness, LLC will only release information that is necessary for billing purposes.

Client Name: _____

Client Signature_____

Today's Date: _____/_____/_____
(This is the date the paperwork was signed by the client)

Witness Signature: _____
(Signed by Phoenix Center Staff only)

Today's Date: _____/_____/_____
(Witnessed on the Date of Admission)

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Demographic Face Sheet

Problems and Concerns

What is the greatest concern for which you are seeking counseling?

Do you have thoughts of feelings of hurting yourself? If so, have you acted on them?

Have you been in counseling previously? If so where and what were the results?

What goals would you like counseling to help to achieve?

Do you have anything else important you would like to share with your therapist?

Client Signature: _____

Date: _____/_____/_____

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Client Consent for Treatment

I_____, agree to enter Phoenix Center for Health and Wellness drug and alcohol and mental health treatment program and give consent to receive treatment as deemed appropriate by the Phoenix Center for Health and Wellness clinical personnel. I also understand that Phoenix Center for Health and Wellness personnel are obliged to provide treatment in a respectful and ethical manner. No guarantees have been made to me as to the results that may be obtained from the program. I understand that during treatment I may engage in several forms of therapy e.g., individual and group counseling an educational session.

I understand that during my course of treatment certain medical or psychiatric procedures may be required by referral agencies and that I have the right to discuss and refused the use of any recommended medication.

I understand that information concerning my name and other identifying personal data from my records may be released without my specific consent in the event of a medical emergency, an in accordance with applicable Federal confidentiality regulations outlined in the release of the information form. I also understand that I may be asked to authorize by separate consent the notification of authorized officials who are responsible for me being in the treatment. I also understand that my disclosure referred two extends only to the release of required data to ensure that Phoenix Center for Health and Wellness maintains its operation in accordance with Federal, State, and specific HIPAA regulations.

I have been given Phoenix Center for Health and Wellness material that explains the admission and discharge criteria, client rights, and rules and regulations.

My signature denotes my consent to treatment under one of the following conditions:

_____I have read all this form and the client rights form and understand the provision of both forms and give my informed consent.

_____I cannot read and this form has been read to me by _____ and I understand the provision of both forms and give my informed consent to treatment.

Client Signature:_____Date:_____/_____/_____

Witness Signature:_____Date:_____/_____/_____
(Signed and Dated: Phoenix Center Staff only)

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Consent for Release of Confidential Health Information to YOUr Center LLC

This document represents a written consent for disclosure of HIPPA protected health information and/or part 2 information.

I_____, authorize Phoenix Center for Health and Wellness.
(Please Print your Full Name)

A drug or alcohol treatment program that is licensed in the State of Delaware, Department of Health and Social Services, Division of Substance Abuse and Mental Health, including any drugs or alcohol treatment program that provides a combination of mental health and drug or alcohol treatment to disclose to:

Your Center LLC, 222 Philadelphia Pike Ste 4, Wilmington, DE 19809
(Names of person or organization to which disclosure is to be made)

The following information: Clinical Referral Information
(State the Nature and amount of information to be disclosed as limited as possible)

The purpose of the disclosure authorized in the written consent is: (Please be specific): *Coordination of Care*

I understand that my substance use disorder treatment records are protected under the Federal regulation governing Confidentiality and Drug Abuse Patient Record, 42 CFR, Part2, and the Health Insurance Portability and Accountability Act of 1996, 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it.

I understand that generally, a treatment program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Client Signature_____

Today's Date: _____/_____/_____
(This is the date the paperwork was signed by the client)

Witness Signature: _____
(Signed Phoenix Center Staff only)

Today's Date: _____/_____/_____
(This is witnessed on the Date of Admission)

This authorization is good one year from the witness signature date: _____/_____/_____
Date of Expiration

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Consent for Release of Confidential Health Information for Primary Care Physician

I, _____ (Client's Full Name), authorize Phoenix Center for Health and Wellness. A drug or alcohol treatment program that is licensed in the State of Delaware, Department of Health and Social Services, Division of Substance Abuse and Mental Health.

_____ Request information from the individuals/ or organization listed below.
_____ Release information from my medical records to the individual/or organization below.

Primary Care Physician: _____
ADDRESS: _____

Reason For the following information may be disclosed:
__x__ Complete Records ____ History & Physical Exam ____ Progress Notes
_____ Lab Records ____ Treatment Records ____ Hospital Records
_____ Other (please specify) _____

For the following purpose, use, or need: *Coordination of Care*

_____

I understand that my substance use disorder treatment records are protected under the Federal regulation governing Confidentiality and Drug Abuse Patient Record, 42 CFR, Part2, and the Health Insurance Portability and Accountability Act of 1996, 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it.

I understand that generally, a treatment program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Client Signature_____

Today's Date: _____/_____/_____
(This is the date the paperwork was signed by the client)

Witness Signature: _____
(Signature of Phoenix Center Staff only)

Today's Date: _____/_____/_____
(This is witnessed on the date of admission)

This authorization is good for one year from the witness signature date: _____/_____/_____
Date of Expiration

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Consent for Release of Confidential Health Information

I, _____ (Client's Full Name), authorize Phoenix Center for Health and Wellness. A drug or alcohol treatment program that is licensed in the State of Delaware, Department of Health and Social Services, Division of Substance Abuse and Mental Health.

_____ Request information from the individuals/ or organization listed below.
_____ Release information from my medical records to the individual/or organization below.

Organization or Person Name: _____
ADDRESS: _____

Reason For the following information may be disclosed:
__x__ Complete Records ____ History & Physical Exam ____ Progress Notes
____ Lab Records ____ Treatment Records ____ Hospital Records
____ Other (please specify) _____

For the following purpose, use, or need: *Coordination of Care*

I understand that my substance use disorder treatment records are protected under the Federal regulation governing Confidentiality and Drug Abuse Patient Record, 42 CFR, Part2, and the Health Insurance Portability and Accountability Act of 1996, 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it.

I understand that generally, a treatment program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Client Signature_____

Today's Date: _____/_____/_____
(This is the date the paperwork was signed by the client)

Witness Signature: _____
(Signature of Phoenix Center Staff only)

Today's Date: _____/_____/_____
(This is witnessed on the date of admission)

This authorization is good for one year from the witness signature date: _____/_____/_____
Date of Expiration

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Authorization to Release Information to Emergency Contact

Client Name:_____**Date:**_____/_____/_____

In the event of a medical emergency, I authorize Phoenix Center for Health and Wellness to release my information to the person(s) listed below.
By signing this form, I understand and agree I voluntarily release this emergency contact information as they may provide necessary judgement for my medical care.

I acknowledge I am responsible for providing any updated emergency contact information to Phoenix Center for Health and Wellness.

I,_____, hereby voluntarily consent to allow Phoenix Center for Health and Wellness to release my medical information to the following emergency contact person (2).

Emergency Contact(s) Information:
Contact #1
Name:_____**Relationship:**_____
Phone: _____
Home_____
Mobile _____
Email: _____

_____***I do not have an emergency contact and do not give Phoenix Center for Health and Wellness consent to release information.***

Client Signature_____

Today's Date: _____/_____/_____
(This is the date the paperwork was signed by the client)

Witness Signature: _____
(Signature of Phoenix Center Staff only)

Today's Date: _____/_____/_____
(This is witnessed on the Date of admission)

This authorization is good one year from the witness signature date: _____/_____/_____
Date of Expiration

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Authorization For the Disclosure Of Protect Health Information

Client Name:_____ **Date of Birth:**_____

Appointment Reminders: Phoenix Center for Health and Wellness, LLC may use your information to remind you about upcoming appointments, educational newsletters, general practice policies and/or changes, upcoming events. Typically, appointment reminders are made by text messaging, emails, and by phone calls, or a brief, non-specific message left on your voicemail.
Please let us know how you wish to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your care provided at Phoenix Center for Health and Wellness, LLC. (Check all that apply)

May we leave a message at your home number? If yes, Detailed: Call back number only:	Yes	No
May we leave a message on your cell phone? If yes, Detailed: Call back number only:	Yes	No
May we leave a message on your work phone number? If yes, Detailed: Call back number only:	Yes	No
May we email you written communications? * If yes, email address:	Yes	No

If "NO" to all above listed, how may we contact you regarding this information?

_____

Please list any other restrictions regarding messages or reminders about your healthcare:

_____

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Practices" and/or consent requires your specific written authorization. If you change your mind about authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. You have the right to request restrictions on the use and disclosure of your health information. *NOTE: As we cannot guarantee the privacy and security of individual patients' email accounts, we refrain from communicating about sensitive clinical matters via email.
By signing this document, I certify that I have read and understand the Use of PHI document.

Client Signature_____ **Date**_____

Witness Signature_____ **Date**_____
(Signed and dated by Phoenix Center Staff Only)

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Peer Support Recovery Specialist Consent for Training

I_____, agree to participate in Phoenix Center for Health and Wellness drug and alcohol and mental health treatment program. I agree to attend training as a Peer Support Recovery Specialist and give Phoenix Center for Health and Wellness full permission to bill my health insurance during my training.

Peer Recovery Specialists are specially trained professionals who support others going through similar life challenges they once experienced. They assist individuals in developing the skills and resources they need to live an independent and productive life in the community.

[x] **I will use my training and skill learned as a tool to help me matriculate in society. I understand that during training I may engage in several forms of therapy e.g., individual and group counseling an educational session.**

[x] **I understand that information concerning my name and other identifying personal data from my records may be released without my specific consent in the event of a medical emergency, an in accordance with applicable Federal confidentiality regulations outlined in the release of the information form. I also understand that I may be asked to authorize by separate consent the notification of authorized officials who are responsible for me being in the treatment. I also understand that my disclosure referred two extends only to the release of required data to ensure that Phoenix Center for Health and Wellness maintains its operation in accordance with Federal, State, and specific HIPAA regulations.**

My signature denotes my consent to Peer Support Recovery Specialist Training under one of the following conditions:

_____I have read all this form and give consent for Phoenix Center for Health and Wellness to bill my insurance during my training hours.

_____I cannot read and this form has been read to me by_____ and I give consent for Phoenix Center for Health and Wellness to bill my insurance during my training hours.

Client Signature:_____Date:_____/_____/_____

Witness:_____Date:_____/_____/_____

(Signed and Dated by Phoenix Center Staff Only)

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Primary Care Physician Referral

Date: _____

Client Full Name: _____
Address: _____
Email: _____
Phone: _____

Re: Phoenix Center for Health and Wellness Primary Care Referral

Please contact the client for the next available appointment.

Phoenix Center for Health and Wellness Center is providing you with this referral to a primary care physician. A primary care doctor, sometimes called a primary care physician or PCP, is a health care professional who practices general medicine for routine and non-urgent conditions. They are skilled in first contact and continuing care for your health concerns. PCPs promote healthy habits, provide preventive care, and help coordinate other health services to help you get and stay healthy.

Below you will find the contact information for the recommended PCP is our area. Please contact the selected provider to make your appointment.

_____**Family Medicine at Wilmington Health Center**
Wilmington Hospital
501 W. 14th St. Wilmington, DE 19801
Phone: 302- 477-3300 Fax 302-255-1225

_____**Westside Family Health Care**
1802 W. 4th St Wilmington, DE 19805
Phone: 302-655-5822 Fax 302-322-6201

_____**Henrietta Johnson Medical Center**
601 New Castle Avenue, Wilmington, DE 19801
Phone: 302 - 655 - 6187 Fax: 302 - 654 -1060

Client Signature:_____**Date:**_____

Witness:_____**Date:**_____
(Signed and dated by Phoenix Center Staff only)

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Client Rights

You Have the Right To:

1. Impartial access to treatment service regardless of race, color, religion, creed, national origin, age, gender, gender expression, sexual orientation, handicap, sexual preference, social economic status, language, or marital status.
2. Receive adequate and humane service regardless of the source ofsupport.
3. Have services provided within the least restrictive environment possible.
4. Receive an individualized treatment plan.
5. Periodically review his /or her treatment plan.
6. Be provided with an adequate number of competent, qualified, and experienced professional clinical staff to supervise and implement the treatment plan.
7. Personal privacy which is a assured and protected within the constraints of the individual treatment plan.
8. Request the opinion of a consultant at his or her expense or to request an in-house review of the individual treatment plan, as provided in specific procedures of the organization.
9. No participating in current and future use and deposition of special observation an audio-visual technique such as one-way vision mirror, tape recorders, television, movies, or photographs.
10. Refuse to participate in any research projects without compromising the patient's access to the organizational services.
11. As appropriate, to have the cost itemized when possible of services rendered.
12. Be told the source of reimbursement treatment an any limitations put on treatment because of this.
13. Initiate a complaint or grievance procedure and have it heard by the appropriate staff.
    Be sure that no retaliation will occur because of the complaint.
14. Review his or hers records and must submit this request through the primary counselor.
15. Have all content clearly explained to him or her prior to signing.
16. Be treated with dignity and respect at all times.
17. Have records maintained in a confidential manner and not be released unless there is written release or there is medical emergency, suspected criminal activity on premises, or for report of child abuse or neglect.
18. Freedom from abuse, exploitation, retaliation, humiliation, and neglect.

Client Signature:_____ **Date:**____/____/____

Witness Signature:_____ **Date:**____/____/____

(Signed and Dated by Phoenix Center Staff Only)

Effective date: 1.2023

Phoenix Center for Health and Wellness, LLC
222 Philadelphia Pike, Ste. 4 Wilmington, DE 19809
Phone: 302-298-3818 Fax:1- 888-801-2676

NOTICE OF PRIVACY PRACTICES

Client Name: _____ D.O.B_____/_____/_____

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.

OUR OBLIGATIONS:
We are required by law to:
-Maintain the privacy of protected health information.
-Give you this notice of our legal duties and privacy practices regarding health information about you.
-Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:
The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing our practice Privacy Officer.

For treatment: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technician, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment: We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations: We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all our patients receive quality care and to operate and manage our office. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services: We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: When appropriate, we may share health information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We may also notify your family about location or general condition or disclose such information to an entity assisting in a disaster relief effort.

SPECIAL SITUATIONS:
As required by Law: We will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use

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another company to perform billing services on our behalf. All our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Military and Veterans: If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation: We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health Risks: We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury, or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect, sexual trafficking, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Date Breach Notification Purposes: We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your Health Information.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons, or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors: We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities: We may release Health Information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody: If you are an inmate or a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This

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release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT:

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief: We may disclose your Health Information to disaster relief organizations that seek your Health Information to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we can practically do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES:

The following uses and disclosures of your Health Information will be made only with your written authorization:

1. Uses and disclosures for Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Health Information.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy: You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Phoenix Center for Health and Wellness, LLC, 222 Philadelphia Pike, Ste. 4 Wilmington, DE 19809.

We have up to 30 days to make your Health Information available to you, and we may charge you a reasonable fee for the cost of copying, mailing, or other supplies associated with your request. We may not charge you a fee if you need the information for claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records: If your Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Health Information in the form or format you request, if it is readily producible in such form or format. If the Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable fee, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured Health Information.

Right to Amend: If you feel that the Health Information, we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by our office. To request an amendment, you must make your request, in writing, to: Phoenix Center for Health and Wellness, LLC, 222 Philadelphia Pike, Ste. 4, Wilmington, DE 19809.

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NOTICE OF PRIVACY PRACTICES

Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request and accounting of disclosures, you must make your request, in writing, to: Phoenix Center for Health and Wellness, LLC, 222 Philadelphia Pike, Ste. 4, Wilmington, DE 19809.

Right to Request Restrictions: You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to: Phoenix Center for Health and Wellness, LLC, 222 Philadelphia Pike, Ste. 4, Wilmington, DE 19809. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Health Information to a health plan for payment or health care operation and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out of pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out of Pocket Payments: If you paid out of pocket (or in other words, if you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications: You have the right to request that we communicate only with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by phone at work. To request confidential communications, you must indicate your choice on the Protected Health Information form. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

CHANGES TO THIS NOTICE:
We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Privacy Officer by writing to: Phoenix Center for Health and Wellness, LLC, 222 Philadelphia Pike, Ste. 4, Wilmington, DE 19809. All complaints must be made in writing. You will not be penalized for filing a complaint.

By signing this document, I certify that I have read and understand the Notice of Privacy Practices of Phoenix Center for Health and Wellness, LLC.

Client Signature:_____ **Date:**_____

Witness Signature:_____ **Date:**_____

(This is witnessed and dated by Phoenix Staff Only)

*A copy of this form will be provided at your request.
*Policy is subject to change.

Phoenix Center for Health & Mental Wellness, LLC
222 Philadelphia Pike, Ste. 4 Wilmington, DE 19809
Phone: 302-543-5321 Fax: 888-801-2676

Acknowledgment of Client Handbook

I have read and been informed about the content, requirements, and expectations of the policy for employees at Phoenix Center For Health and Wellness.

I have received a copy of the policy and agree to abide by the policy guidelines. By signing this document, I am acknowledging I have received and reviewed the Client Handbook for Phoenix Center For Health and Wellness.

I understand that if I have questions, at any time, regarding the policy, I will consult with my immediate supervisor or my Human Resources staff members.

Client Name: _____

Client Signature: _____

Date: _____/_____/_____

Witness Signature: _____**Date**: _____/_____/_____
(Signed and Dated by Phoenix Center Staff Only)