Centered On You
COUNSELING & CONSULTING

Client Information Form

This form is completely confidential

Today's date: _____

Your name:

_____

Last **First** **Middle Initial**

Date of birth: _____ **Social Security #:** _____

Home street address: _____

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

Name of Employer: _____

Address of Employer: _____

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

Home Phone: _____ Work **Phone:** _____

Cell Phone: _____ **Email:** _____

Calls will be discreet, but please indicate any restrictions: _____

_____

Referred by: _____

- May I have your permission to thank this person for the referral?
- If referred by another clinician, would you like for us to communicate with one another? Y___N____

Person(s) to notify in case of any emergency: _____

Name **Phone**

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Please briefly describe your presenting concern(s): _____

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

3350 Northlake Pkwy, NE, Suite B-3
Atlanta, GA 30045
drmoon@centeredonyoucounseling.com
470-525-0033

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

**The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing. **

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____
_____
_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day? _____
Do you consume caffeine? YES NO If YES, how much per day? _____
Do you drink alcohol? YES NO If YES, how much per day/week/month/year? _____
Do you use any non-prescription drugs? YES NO
If YES, what kinds and how often? _____
Have any of your friends or family members voiced concern about your substance use? YES NO
Have you ever been in trouble or in risky situations because of your substance use? YES NO
Previous medical hospitalizations (Approximate dates and reasons): _____
_____
_____
Previous psychiatric hospitalizations (Approximate dates and reasons): _____
_____
_____
Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____
_____
_____

Height _____ Weight (if applicable) _____ Age_____ Gender _____
Sexual Identity: Heterosexual__ Lesbian__ Gay__ Bisexual__ Transgender__ In Question__

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FAMILY:

How would you describe your relationship with your mother? _____
_____
_____

How would you describe your relationship with your father? _____
_____
_____

Are your parents still married? _____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____
_____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____
_____

How many sisters do you have? _____ Ages? _____
How many brothers do you have? _____ Ages? _____
How would you describe your relationships with your siblings? _____
_____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

POOR EXCELLENT
Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: 1 2 3 4 5 6 7

Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships_____

Do you have Children? ____ If YES, how many and what are their ages: _____

Describe any problems any of your children are having: _____
_____

List the names and ages of those living in your household: _____
_____
Please briefly describe any history of abuse, neglect and/or trauma: _____
_____
_____

POOR EXCELLENT
Current level of satisfaction with your friends and social support: 1 2 3 4 5 6 7

Please briefly describe your coping mechanisms and self-care: _____
_____
_____

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Is spirituality important in your life and if so please explain: _____
_____

Briefly describe your diet and exercise patterns: _____
_____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree (or Higher) ___ Vocational Degree___

What is your current employment? _____

POOR EXCELLENT

Employment Satisfaction: 1 2 3 4 5 6 7

Any past career positions that you feel are relevant? _____
_____

What do you think are your strengths?
_____
_____

Any additional information you would like to include*:*
_____
_____
_____

Please continue to the next page

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xPLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			People in General →			Nausea →		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Concerns			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems			Physical Abuse			Depression		
Legal Trouble			Sexual Abuse			Anxiety		
Domestic Violence			Hyperactivity			Psychiatric Hospitalization		

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Suicide			Learning Disabilities			"Nervous Breakdown"		

Signature: _____

Date: _____

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Informed Consent Form for Adults

Welcome to Centered on You Counseling and Consulting, LLC. I am grateful that you selected my practice for your behavioral needs and I look forward to working with you. This document is designed to inform you what to expect from me as your therapist regarding the treatment processes, policies, procedures and other details regarding your treatment. Although providing this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with me is a collaborative one, and I welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Psychological Services

Psychotherapy refers to a variety of mental health interventions provided by a licensed mental health professional to a client. It works, in part, because of clearly defined rights and responsibilities held by each person, which helps create an atmosphere of safety and support needed to take steps toward change.

Psychotherapy has been shown to have many benefits including the reduction of emotional distress, improved relationships, and solutions to specific problems. Risks of psychotherapy may include temporary unpleasant emotions that can result from discussing and reflecting on unpleasant aspects of your life. There are no guarantees about what will happen. To be most successful, you will have to work on things we discuss outside of sessions.

Therapist Background Information, Theoretical View & Client Participation

I believe you already have the necessary tools within to create peace and fulfillment in your life. However, sometimes you may need guidance in constructing new pathways of wholeness and correcting unhealthy patterns of thinking and behaving. My theoretical view incorporates Cognitive Behavior, Solution-Focused Therapy, Narrative Therapy, along with integrating complementary methodologies and techniques specific to your needs. For therapy to be most successful, it is important for you to take an active role. This means working on the things you and I talk about both during and between sessions. Generally, the more of yourself you are willing to invest, the greater the return. I promise that I will be there with you every step of your growth process.

My experience includes the following: Licensed Professional Counselor, National Certified Counselor, Approved Clinical Supervisor and a PhD from the University of Georgia in Counseling. I have been in the counseling field for over 13 years and trained to provide individual counseling to adults and adolescents with a range of psychological issues.

Initials _____

Confidentiality

Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in my locked office. Additionally, I will always keep everything you say to me completely confidential, with the following exceptions: (1) you direct me to tell someone else and you sign a “Release of Information” form; (2) I determine that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled

individual who may require protection; or (4) I am ordered by a judge to disclose information.
Initials _____

Initial Session

The initial meeting will be 60 minutes in length. The next few sessions will involve a comprehensive evaluation of client's needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.
Initials _____

APPOINTMENTS

Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice. Failure to comply with this policy will result in a missed appointment fee of $60 [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time to ensure other clients' appointments are not impacted. Doing psychotherapy by telephone is not ideal, and needing to talk to me between sessions may indicate that you need extra support. If this is the case, you and I will need to explore adding sessions or developing other resources you have available to help you. Telephone calls that exceed 10 minutes in duration will be billed in increments of 10 minutes.
Initials _____

STRUCTRE AND FEES

The standard fee for the initial intake is $125.00 and each subsequent session is $115.00. You are responsible for paying at the time of your session; if you are using insurance, you will be expected to pay the full amount of your copay. Methods of payment include cash and credit/debit. Any services that are not processed will incur a fee of up to $35.00 to cover the fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.
It is my practice to charge $175 an hour for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me.
Initials _____

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INTERACTION WITH THE LEGAL SYSTEM

I understand that I will not involve or engage my therapist in any legal issues or litigation in which I am a party to at any time either during my counseling or after counseling terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litems, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. If I wish to have a copy of my file, and I execute a proper release, my therapist will provide me with a copy of my record. If I believe it necessary to subpoena my therapist, I would be responsible for his or her expert witness fees in the amount of $1,500.00 for one-half (1/2)
day to be paid five (5) days in advance of any court appearance or deposition. Any additional time I spend over one-half (1/2) day would be billed at the rate of $375.00 per hour including travel time. I understand that if I subpoena my therapist, he or she may elect not to speak with my attorney, and a subpoena may result in my therapist withdrawing as my counselor. Initials

_____

INSURANCE

For us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Please contact your insurance company prior to your initial visit to determine what your co-pay is, etc. You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-V. Sometimes I must provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit.

In addition, some insurance companies also have a deductible, which is an out-of-pocket amount, which must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once you obtain all the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my provider contract. If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance

companies reimburse for out-of-network providers, Insurance companies have many rules and requirements specific to certain plans.
Initials _____

TECHNOLOGY STATEMENT

In a technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to me that I maintain your confidentiality, respect your boundaries, and ascertain that your relationship with me remains therapeutic and professional. Therefore, I've developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure and confidential. However, I realize that most people have and utilize a cell phone. I may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with me.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to text and/or email because it is a quick way to convey information. If you choose to utilize texting or email, please discuss this with me. However, please know that it is my policy to utilize these means of communication strictly for brief topics such as appointment confirmations. Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. You also need to know that I am required to keep a copy of all emails and texts as part of your clinical record.

Facebook, LinkedIn, Instagram, Pinterest, Etc.: It is my policy not to accept requests from any current or former client on social networking sites such as Facebook, LinkedIn, Instagram, Pinterest, etc. because it may compromise your confidentiality. You are welcome to follow me on social media. However, please do so only if you are comfortable with the public knowing your name is attached to Centered on You Counseling. If you would like to follow me on any of these media, you might want to consider using an alias to keep your connection with me confidential, but that is entirely your decision.

Twitter & Blogs: I may post psychology news on Twitter or write an entry on a blog. If you have an interest in following either of these, please let me know so that we may discuss any potential implications to our therapeutic relationship. Once again, maintaining your confidentiality is a priority. I would recommend using an RSS feed or locked Twitter list, which would eliminate you having a public link to my content. In summary, technology is constantly changing, and there are implications to all of the above that we may not realize now. Please feel free to ask questions, and know that I am open to any feelings or thoughts you have about these and other modalities of communication.

Google, Bing, etc.: It is my policy not to search for my clients on Google or any other search engine. I respect your privacy and make it a policy to allow you to share information about yourself with me as you feel appropriate. If there is content on the Internet that you would like to share with me for therapeutic reasons, please print this material and bring it to your session.

Faxing Medical Records: If you authorize me (in writing) via a "Release of Information" form to send your medical records or any form of protected health information to another entity for any reason, I may need to fax that information to the authorized entity. It is my responsibility to let you

know that fax machines may not be a secure form of transmitting information. Additionally, information that has been faxed may also remain in the hard drive of my fax machine.

Recommendations to Websites or Applications (Apps): During the course of our treatment, I may recommend that you visit certain websites for pertinent information or self-help. I may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites/apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide and communicate to me if you would like this information as adjunct to your treatment or if you prefer that I do not make these recommendations. In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Please feel free to ask questions, and know that I am open to any feelings or thoughts you have about these and other modalities of communication.

Initials _____

After Hours Support and Emergencies

Centered on You Counseling & Consulting is by appointment only and not an emergency services facility. I do not provide emergency services. You may call me during business hours and leave me a confidential voicemail including your telephone number (even if you know I have it). I will call you back when I have finished all sessions or between sessions when possible. I do not answer calls when I am with clients. I strive to return all calls within 24 hours, though occasionally, it may take up to 48 hours depending on schedule and day of week. When I will be out of the office for an extended period, I update my voicemail and email messages to reflect when I will return and provide all current clients with advance notice. If you have a mental health emergency, call 911 or go to the hospital of your choice FIRST. Only contact me after emergency services have been obtained for your safety. You can also reach me during business hours or on an emergency basis after hours at 470-525-0033. Some additional emergency services facilities include: (not to be substituted for 911 for life threatening emergencies):

Ridgeview Institute 770-434-4567
Summit 678-422-5858
Peachford Hospital 770-455-3200
Go to the nearest emergency room

Initials _____

Release of Information and Records

Clients or their legal guardians often request that I obtain or provide information to other healthcare or mental health professionals, schools, insurance companies, and other relevant parties. For clients over 18, a signed authorization form must be filled out by the client to allow me to speak to anyone regarding their care, even parents. For children and teens, parents or legal guardians must fill out an authorization form before I can even acknowledge knowing the client.

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Pursuant to HIPAA, I keep information about clients in a collection of professional records, known as your clinical record. You may receive a copy of your clinical record if requested in writing. Because these are clinical records, they are easily misinterpreted by untrained readers. For this reason, I recommend reviewing them together within a scheduled session or have them forwarded to another mental health professional so you can discuss the contents. There is an administrative fee of $35 for copying and mailing the record for release.
Initials _____

Quality of Service

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns.
Such comments will be taken seriously and handled with care and respect. You may also request that I refer you/your child to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, you have the right to ask questions about any aspects of therapy and about my specific training and experience. If you feel I have behaved in an unprofessional or unethical manner, please advise me so that the problem can be clarified and resolved. If you feel that this does not resolve the issue, you may contact the following:

Georgia State Department of Licensing
Composite Board of PC, SW & MFT
237 Coliseum Drive
Macon, Georgia 31217
478 207 1670

Initials _____

Our Agreement to Enter into a Therapeutic Relationship

I am sincerely looking forward to working with you. If you have any questions about any part of this document, please ask. Please print, date, and sign your name below indicating that you have read and understand the contents of this "Information, Authorization and Consent to Treatment" form as well as the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices" provided to you separately. Your signature also indicates that you agree to the policies of your relationship with me, and you are authorizing me to begin treatment

_____
Client (or parent/legal guardian of child client) Printed Name

_____ _____
Client (or parent/legal guardian of child client) Signature Date

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Insurance Verification Worksheet

Client Name: _____ **Parent Name:** (if child is client) _____
DOB: _____

Insurance Information: *Please phone your Insurance Company and fill out this form the best you can.*
This is very helpful information if you are unfamiliar with your coverage.

Name of Insurance: _____ **Phone: (____)** _____
Insured's Name: _____
ID #: _____ **Plan/Grp #:** _____

When you call, be sure to write down the name of the person that you talk to for later reference.
HMO Contact Person: _____ **Date & Time of call:** _____
Say, "I'm calling to clarify my benefits and coverage for out-patient mental health." (They will ask for your member ID #) *Ask enough questions to complete all of the information. Incomplete information will require another phone call.*
Is my therapist, Natasha Moon, LPC, or Centered on You Counseling & Consulting, on the Participating Provider List?
If not on their panel, then ask these questions:
"Does my policy allow me to choose my own therapist?" Yes No
"Can I go outside of the panel or the provider list?" Yes No (If so, "Is my coverage different? How?") _____
Then ask: "What is my:
Copay: _____% **or** $ _____**/session. Whichever is less.**
Effective Date of Policy: _____

Deductible? No Yes **Amount of Deductible** $ _____ **family or individual?**
_____
Has any Deductible been met for this year? No Yes **If yes, how much?**
_____
Is Pre-authorization needed? No Yes **Any benefits used to date?** Yes No
 # Visits allowed per calendar year _____

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client's Name: _____ Birth Date: _____

I, _____, authorize, Independent Practitioner, ___Dr. Natasha Moon, LPC_____
Responsible Party Name — Therapist's Name

at Centered on You Counseling & Consulting, LLC, to **[release] [request] [share]** (circle all that apply) confidential medical record information

[to] [from] [with] (circle all that apply), _____ _____ .
Therapist/School Official — Phone

Information shall consist of: Duplicate records and/or verbal consultation concerning treatment and/or education.

Specifically:
☐ All Clinical Records ☐ Educational Evaluation
☐ Mental Health Info ☐
☐ Other: _____

The information is needed for adopting a more comprehensive and integrated approach to my health care and maintaining a continuity of care for this purpose only unless other wise permitted or required by law.

This authorization may be revoked at any time by the client. Revoking of this authorization shall not cancel any prior action that has already transpired. If not revoked, it shall terminate the last day of the clinical treatment.

A photocopy, facsimile or duplicate copy of this authorization shall be as valid as the original.

The person signing this consent has a right to receive a copy of it. My initials, _____ indicate that I have received a copy of this authorization to release medical records.

I have read and understand the nature of this release. I understand that I may revoke it at any time. I release the therapist and the above-named organization from any liability that may arise from this action whether foreseen at present.

_____ _____
Signature of Client — Date

_____ _____ _____
Signature of Legal Representative (If client is a minor or incapacitated) — Relationship to Client — Date

_____ _____
Witness — Date

I do not give my mental health provider permission to contact my primary care physician, therapist or other type of provider.

_____ _____
Signature of Client — Date

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Client's Name: _____ Date of Birth: _____

Parent's Name (if applicable): _____

Health Insurance Portability and Accountability Act (HIPAA) Rights:

I acknowledge Centered on You Counseling & Consulting, LLC adheres to the federal mandates of the HIPAA laws. My signature below acknowledges receipt of this notice. I can receive the full disclose in print, email, or by fax, upon request.

_____ _____
Patient or Authorized Person's Signature Date

AUTHORIZATION FOR BILLING

I authorize the Release of any medical or other information necessary to process my health care claims including a clinician diagnosis, understanding that all information shared is protected health information and will fall in compliance to HIPAA laws.

_____ _____
Patient or Authorized Person's Signature Date

I authorize payment of medical benefits to Natasha Moon, LPC, Centered on You Counseling and Consulting, LLC for healthcare services rendered.

_____ _____
Patient or Authorized Person's Signature Date

Policy Holder's Name:
Address:
Date of Birth:
Cardholder Name if different
Credit Card Type: Visa Mastercard Discover
Credit Card Number:
Expiration Date: **Card ID Number (last 3 digits on back of card)**

Please note: If you miss an appointment or do not cancel within 24 hours in advance; you will be assessed a missed appointment fee.

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HIPAA Notice

Notice of Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

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

"PHI" refers to information in your health record that could identify you.

"Treatment, Payment and Health Care Operations"

Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example would be when I consult with another health care provider, such as your family physician or another psychologist.

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

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

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

"Disclosure" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.

Adult and Domestic Abuse – If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.

Health Oversight Activities – If I am the subject of an inquiry by the Georgia Board of Psychological Examiners, I may be required to disclose protected health information regarding you in proceedings before the Board.

Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order.

The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety – If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.

Worker's Compensation – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Counselor's Duties

Patient's Rights:

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

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

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

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

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

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

Counselor's Duties:

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

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

If I revise my policies and procedures, I will provide you with a revised notice at your next session.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at 470-525-0033.

If you believe that your privacy rights have been violated and wish to file a complaint with me/my office, you may send your written complaint to me at 3350 Northlake Pkwy, NE; Suite B-3; Atlanta, GA 30345.

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

I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect June 2017. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by the time of your next session.