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Client Information – Intake Form

NAME: _____ DATE: _____

DATE OF BIRTH: _____ AGE: _____ MALE/FEMALE_____

ADDRESS: _____

HOME PHONE: _____ May I contact you at this number? _____

CELL PHONE: _____ May I contact you at this number? _____

WORK PHONE: _____ May I contact you at this number? _____

EMAIL ADDRESS: _____ May I contact you at this address? _____

OCCUPATION: (former, if retired): _____

RELATIONSHIP STATUS: single married separated divorced widowed other: _____

FINANCIALLY RESPONSIBLE PARTY (if other than self)

Name: _____ Relationship to you _____

Address: _____

Cell Phone: _____ Home/Work Phone: _____

EMERGENCY CONTACT PERSON

Name: _____ Relationship to you _____

Address: _____

Cell Phone: _____ Home/Work Phone: _____

REFERRAL SOURCE: _____
May we contact them to thank them for the referral?_____

Primary Care Provider: _____ PCP Phone:_____

Can we share records with your physician (release of information) and let them know that you are in therapy? _____

_____ _____

Signature of Client (Parent or Guardian if Minor) Date

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Adolescent Informed Consent
Privacy of Information Shared in Counseling/Therapy: Your Rights and My Policies

What to expect:

The purpose of meeting with a counselor or therapist is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counselor or therapist about these problems. Or, you may be here because your parent, guardian, doctor or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling.

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

>You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.

> You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, and I must inform the person who you intend to harm.

>You are doing things that could cause serious harm to you or someone else, even if you do not intend to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

>You tell me you are being abused-physically, sexually or emotionally-or that you have been abused in the past. In this situation, I am required by law to report the abuse to the Arizona Department of Social Services.

>You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement unless the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

Communicating with your parent(s) or guardian(s):

Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of – or would be upset by – but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will

need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.

Example: If you tell me that you have tried alcohol at a few parties, I would keep this information confidential. If you tell me that you are drinking and driving or that you are a passenger in a car with a driver who is drunk, I would not keep this information confidential from your parent/guardian. If you tell me, or if I believe based on things you've told me, that you are addicted to alcohol, I would not keep this information confidential.

Example: If you tell me that you are having protected sex with a boyfriend or girlfriend, I would keep this information confidential. If you tell me that, on several occasions, you have engaged in unprotected sex with people you do not know or in unsafe situations, I will not keep this information confidential. You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," in other words: "If someone told you that they were doing _____, would you tell their parents?"

Even if I have agreed to keep information confidential – to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

[You should also know that, by law in Arizona, your parent/guardian has the right to see any written records I keep about our sessions. It is extremely rare that a parent/guardian would ever request to look at these records.]

Communicating with other adults:

School: I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission. A very unlikely situation might come up in which I do not have your permission but both I and your parent or guardian believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information.

Doctors: Sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a counselor or therapist. I will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don't have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

* * * * *

Adolescent Consent Form & Parent Agreement to Respect Privacy

Adolescent therapy client:

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time.

Minor's Signature _____ Date_____

* * *

Parent/Guardian:

Check boxes and sign below indicating your agreement to respect your adolescent's privacy:

/___/ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

/___/ Although I know I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my adolescent's treatment.

/___/ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

Parent Signature _____ Date_____

Parent Signature _____ Date_____

Therapist Signature _____ Date_____

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Office Policies & Informed Consent for Psychotherapy

Welcome to therapy! I understand the importance of taking this first step and feel honored that you are trusting me with your psychological treatment.

The following document contains important information about my professional services and business policies. Please read it carefully and discuss any questions you have with me prior to the start of your treatment. Signing this document represents a mutual treatment agreement for psychotherapy between you and Clear Horizons Counseling LLC (Drs. Van Tuinen & Smitham), and indicates an understanding and acknowledgement of the policies presented below.

CLIENT RIGHTS: All clients will be treated equally without regard to gender, age, race/ethnicity, sexual orientation, religion, and/or disability. As a client of Clear Horizons Counseling LLC, you will be treated with dignity and respect.

CONFIDENTIALITY: All information disclosed within sessions and the written or electronic records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law.

WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW: Some of the circumstances where disclosure is required or may be required by law are: when a client's family members communicate to Clear Horizons that the client presents a danger to self or others. Disclosure may also be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Clear Horizons Counseling LLC. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. Your therapist will use her clinical judgment when revealing such information. Clear Horizons Counseling LLC will not release records to any outside party unless authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult clients.

MANDATED REPORTING: As a mental health professionals, Drs. Van Tuinen and Smitham are mandated reporters and are required by law to breach confidentiality in certain situations. Information that must be reported according to state guidelines includes: reasonable suspicion of physical, emotional, and/or sexual abuse or neglect of a minor or disabled adult; information regarding a minor's exposure to or participation in illegal activities with adults; reports of the intention to harm self and/or others; and in cases where client records and/or Dr. Van Tuinen or Dr. Smitham is court subpoenaed.

EMERGENCY: If there is an emergency during therapy, or in the future after termination, where Dr. Van Tuinen or Dr. Smitham becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, she will do whatever she can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, she may also contact the person whose name you have provided as your emergency contact on the client information form.

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/EAP in order to process the claims. If you so instruct your therapist, only the minimum necessary information will be communicated to the carrier. Your therapist has no control over, or knowledge of, what insurance companies do with the information she submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance.

LITIGATION LIMITATION: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on Dr. Van Tuinen or Dr. Smitham to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

CONSULTATION: Drs. Smitham and Van Tuinen consult regularly with other professionals regarding their clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained.

E–MAILS, CELL PHONES, COMPUTERS, AND FAXES: It is very important to be aware that computers and unencrypted e-mail, texts, and e-faxes communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. While data on Dr. Van Tuinen's and Dr. Smitham's computer, iPad, and cell phone are encrypted, e-mails and e-faxes are not. It is always a possibility that e-faxes, texts, and email can be sent erroneously to the wrong address and computers. Dr. Van Tuinen's and Dr. Smitham's electronic devices are equipped with a firewall, a virus protection and a password, and they back up all confidential information from their computers on a regular basis onto an encrypted hard-drive. Please notify your therapist if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phone calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, your therapist will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and she will honor your desire to communicate on such matters. Please do not use texts, e-mail, voice mail, or faxes for emergencies.

TREATMENT OF MINORS: Treatment of minors under 18 must be authorized by the child's parent(s) or legal guardian(s). In situations where the minor's parents are not legally married, it is standard practice that prior to beginning treatment, your therapist must receive written consent for treatment from both parents, and, when appropriate, a copy of the parents' custody agreement. Additionally, both parents' written authorization is required to release the minor's records to any third party.

RECORDS AND YOUR RIGHT TO REVIEW THEM: Both the law and the standards of Dr. Van Tuinen's and Dr. Smitham's profession require that they keep treatment records for at least seven years. Unless otherwise agreed to be necessary, your therapist retains clinical records only as long as is mandated by Arizona law. If you have concerns regarding the treatment records, please discuss them with your therapist. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when your therapist assesses that releasing such information might be harmful to you in any way. In such a case, your therapist will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, and upon your request, your therapist will release information to any agency/person you specify unless she assesses that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, your therapist will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

CONTACT & EMERGENCY PROCEDURES: If you need to contact your therapist between sessions, please call or leave a confidential message on her phone at (480) 839-1583 and your call will be returned as soon as possible. Drs. Van Tuinen and Smitham check their messages a few times during the daytime only, unless they are out of town. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone immediately call the Maricopa County Crisis Line: (602)222-9444 and 1-800-631-1314 or the Police: 911. Please do not use email, faxes, or texts for emergencies. Your therapist does not always check her email or faxes daily. In the case that Dr. Van Tuinen or Dr. Smitham will be unavailable for an extended period of time, you will be given the name and contact information of another qualified mental health provider who will be available to assist you until your therapist returns.

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay the standard fee of $150.00 per 50 minute session at the end of each session unless other arrangements have been made. Telephone conversations, site visits, writing and reading of reports, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Please notify your therapist if any problems arise during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, your therapist will provide you with a copy of your receipt at the end of each session, which you can then submit to your insurance company for reimbursement, if you so choose. As was indicated in the section, Health Insurance & Confidentiality of Records, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are dealt with in psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. Unfortunately, your insurance may deny or refuse coverage of services provided by Clear Horizons Counseling. Therefore, you are fully responsible for all fees charged, whether or not these charges are denied and/or not covered by your insurance.

If you have coverage through Medicare, please note that Clear Horizons Counseling has elected to opt out of this program. As a result, Medicare mandates that you will not be allowed to bill Medicare on your own and/or request that Dr. Van Tuinen or Dr. Smitham submit a bill to Medicare.

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Participation in psychotherapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. Your therapist will ask for your feedback and views on your therapy, its progress, and other aspects of the treatment and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. Your therapist may challenge some of your perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, your therapist is likely to draw on various psychological approaches according, in part, to the problem that is being treated and her assessment of what will best benefit you. These approaches include, but are not limited to, cognitive-behavioral, cognitive, family systems, humanistic or psycho-educational. Dr. Van Tuinen and Dr. Smitham do not provide custody evaluation recommendation nor medication or prescription recommendation nor legal advice, as these activities do not fall within their scope of practice.

TREATMENT PLANS: Within a reasonable period of time after the initiation of treatment,
your therapist will discuss with you her working understanding of the problem, treatment plan, therapeutic objectives, and her view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, your therapist's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits.

TERMINATION: As set forth above, after the first several sessions, your therapist will assess if she can be of benefit to you. Dr. Van Tuinen and Dr. Smitham do not work with clients who, in their opinion, they cannot help. In such a case, if appropriate, they will give you referrals that you can contact. If at any point during psychotherapy your therapist either assesses that she is not effective in helping

you reach the therapeutic goals or perceives you as non-compliant or non-responsive, and if you are available and/or it is possible and appropriate to do, she will discuss with you the termination of treatment and conduct pre-termination counseling. In such a case, if appropriate and/or necessary, she would give you at least two referrals that may be of help to you. If you request it and authorize it in writing, your therapist will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, Dr. Van Tuinen or Dr. Smitham will give you appropriate referrals that you may want to contact, and if she has your written consent, she will provide her or him with the essential information needed. You have the right to terminate therapy and communication at any time. If you choose to do so, upon your request and if appropriate and possible, your therapist will provide you with names of other qualified professionals whose services you might prefer.

CANCELLATION POLICY: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hour notice is required for re-scheduling or canceling an appointment. A full fee will be charged for not showing for your appointment and/or for sessions missed without 24 hour notification. Most insurance companies do not reimburse for late cancellations or missed sessions, therefore you will be fully responsible for any fees charged due to late cancellations and/or no show appointments.

I have read the above Office Policies and Informed Consent for Psychotherapy carefully (a total of 4 pages); I understand them and agree to comply with them:

Client's Name (print) _____

Client Signature _____ Date_____
(Parent or Guardian if Minor)

Therapist's Name (print) _____

Signature _____ Date _____
Therapist, Clear Horizons Counseling, LLC

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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 as permitted by law. 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. You may also request a copy of this Notice from me, or you can view a copy of it in my office which is located at: 1007 E Warner Rd, Ste 105, Tempe, AZ 85284.

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.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.
I may use and disclose your PHI without your consent for the following reasons:
1. For treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my partners and interns. 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: I may 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.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
4. If disclosure is compelled by the patient or the patient's representative pursuant to Arizona Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.
5. To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds).
6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
7. If disclosure is mandated by the Arizona Child Abuse and Neglect Reporting law. For example, if I have a reasonable suspicion of child abuse or neglect.
8. If disclosure is mandated by the Arizona Elder/Dependent Adult Abuse Reporting law. For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. For health oversight activities. Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.
13. Appointment reminders and health related benefits or services. Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer.
14. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
15. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
16. If disclosure is otherwise specifically required by law.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.
1. 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.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI
These are your rights with respect to your PHI:
A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must

deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.
If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.
B. 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.
C. 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). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.
D. 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 seven 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 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.
E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. 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.
F. 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. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at:
Clear Horizons Counseling LLC
1007 E Warner Rd, Ste 105
Tempe AZ 85284

VII. NOTIFICATIONS OF BREACHES

In the case of a breach, your therapist is required to notify each affected individual whose unsecured PHI has been compromised. Even if such a breach was caused by a business associate, your therapist is ultimately responsible for providing the notification directly or via the business associate. If the breach involves more than 500 persons, OCR must be notified in accordance with instructions posted on its website. Your therapist bears the ultimate burden of proof to demonstrate that all notifications were given or that the impermissible use or disclosure of PHI did not constitute a breach and must maintain supporting documentation, including documentation pertaining to the risk assessment.

VIII. PHI AFTER DEATH

Generally, PHI excludes any health information of a person who has been deceased for more than 50 years after the date of death. Your therapist may disclose deceased individuals' PHI to non-family members, as well as family members, who were involved in the care or payment for healthcare of the decedent prior to death; however, the disclosure must be limited to PHI relevant to such care or payment and cannot be inconsistent with any prior expressed preference of the deceased individual.

IX. Individuals' Right to Restrict Disclosures; Right of Access

To implement the 2013 HITECH Act, the Privacy Rule is amended Clear Horizons Counseling, LLC is required to restrict the disclosure of PHI about you, the patient, to a health plan, upon request, if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law. The PHI must pertain solely to a healthcare item or service for which you have paid the covered entity in full. (OCR clarifies that the adopted provisions do not require that covered healthcare providers create separate medical records or otherwise segregate PHI subject to a restrict healthcare item or service; rather, providers need to employ a method to flag or note restrictions of PHI to ensure that such PHI is not inadvertently sent or made accessible to a health plan.)

The 2013 Amendments also adopt the proposal in the interim rule requiring your therapist, to provide you, the patient, a copy of PHI to any individual patient requesting it in electronic form. The electronic format must be provided to you if it is readily producible. OCR clarifies that your therapist must provide you only with an electronic copy of their PHI, not direct access to their electronic health record systems. The 2013 Amendments also give you the right to direct your therapist to transmit an electronic copy of PHI to an entity or person designated by you. Furthermore, the amendments restrict the fees that Your therapist may charge you for handling and reproduction of PHI, which must be reasonable, cost-based and identify separately the labor for copying PHI (if any). Finally, the 2013 Amendments modify the timeliness requirement for right of access, from up to 90 days currently permitted to 30 days, with a one-time extension of 30 additional days.

X. NPP

Clear Horizons Counseling LLC NPP must contain a statement indicating that most uses and disclosures of psychotherapy notes, marketing disclosures and sale of PHI do require prior authorization by you, and you have the right to be notified in case of a breach of unsecured PHI.

XI. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on September 23, 2013

I acknowledge receipt of this notice

Client Name: _____ Date: _____

Client Signature: _____

(Parent or Guardian if Minor)

clear horizons
walking along with you on the road to recovery

Insurance Billing Authorization Form

Client Full Name: _____ Date: _____

Client Birthdate:_____

Insurance Company:_____ Effective Date/When Coverage Began: _____

Identification Number: _____ Group Number: _____

Type of Plan (HMO/PPO) _____ Do you owe a co-pay? If so, now much _____

Do you have a deductible for mental health services?_____. If so, have you met it already?_____

Does your insurance require pre-certification for mental health services?_____ If so, have you obtained this? _____

Insurance Mailing Address: _____

Name of Insurance Holder: _____ Relationship to this person: _____

Birthdate of Insurance Holder: _____ Social Security Number of Holder: _____

Employer of Insurance Holder: _____
Name of company/Address of company/Phone number

By signing below, I am stating that I understand that:

_____ Regardless of insurance status (co-pay or full rate if deductible is not met), payment is due at the time of service

_____ I am giving authorization to my provider(s) to share PHI including diagnostic and treatment plan information with my insurance company

Signature of client: _____ Date: _____