Psychology * Wellness Practice

Child Registration Form

Name:			**Date:**
Street:	**Suite/Apt. #**		**Date of Birth:**
City:	**State:**		**Zip Code:**
Phone (home):	**Phone (work):**		
Cell Phone:	**Email Address:**		
Name of person to call in an emergency:			**Relationship:**
Street:			**Suite/Apt. #:**
City:	**State:**		**ZIP code:**
Phone:			
Name of person filling out this form (if not patient):			
Name of Primary Care Physician (PCP):			**Date last seen:**
PCP Office Address:			**Suite/Apt. #:**
City:	**State:**		**ZIP code:**
Phone:	**Fax:**		

Consent for Child and Adolescent Therapy

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Outpatient Services Agreement. Under HIPAA and the APA Ethics Code, I am legally and ethically responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise. One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship. Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records. It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you. Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done. Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, should I be involved in legal proceedings, it is agreed that my services will be paid for by the responsible party at my then current rates per hour of time.

______________________________________ ____________________

Parent/Guardian Signature Date

______________________________________ ____________________

Witness Signature Date

____

Outpatient Services Contract – Andrea Janczyk, LMHC

Welcome to the practice! This document contains important information about my professional services and business policies. Please read it carefully and write down any questions you might have so that we can discuss them. When you sign this document, it will represent an agreement between us. **MEETINGS:** I normally conduct an initial diagnostic assessment, via clinical interview, that lasts 1 session. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-minute session (one appointment hour of 45 minutes duration) for family therapy and one 53 minute session for individual therapy. Appointments are time-based and, therefore, it is important that we begin our sessions on time. Sessions that are started more than 10 minutes late are subject to a partial private pay fee. Sessions will be scheduled at a time we agree on, although some sessions may be longer or shorter, or more or less frequent. **CANCELLATION POLICY:** Most days, there is a waiting list of patients who are eager to set up an appointment as soon as possible. As such, it is important to keep your appointment for the time it was scheduled. Appointments that are cancelled more than 24 hours in advance will *not* be charged a cancellation fee. Appointments that are cancelled the day prior to your scheduled appointment but less than 24 hours in advance will be charged a $40.00 cancellation fee. These calls must be received before 5:00pm. Appointments that are cancelled the same day as scheduled are subject to a $50.00 late cancellation fee. If you do not show to your scheduled appointment without a prior phone call, a $90.00 fee is charged. **DISCHARGE POLICY**: You are eligible for immediate discharge if: 1) You cancel 3 appointments in a short period of time; 2) You miss more than 2 appointments without advanced notice; 3) You do not provide payment as discussed; 4) You have not scheduled an appointment/been seen for an appointment for 90 days; 5) You have not followed through with any therapy assignments after 3 sessions; *If you or your child is not ready for therapy, that's understandable, and we can try another time; however, I need to be mindful of those who are on a waiting list and eager to begin therapy.* **PROFESSIONAL FEES:** ***Out-of network****:* If I do not accept your insurance, I can still provide my services as an out of network provider. In that case, my fee for psychotherapy sessions is $90.00. ***Insurance:*** Applicable insurance fees (e.g., copay) are required for each psychotherapy and psychological testing session at the time of service when held in the office. **A $10.00 charge will be applied to all copays not paid at the time of service**. **We accept cash and personal check for appointments held in the office**. Applicable insurance fees (e.g., copay) are charged to the credit card on file for telehealth appointments. Please make checks payable to Psychology Wellness Practice, PLLC. ***Other****:* Insurance companies do not reimburse for preparation of records for a third party or at your request. As such, those services are billed at a private pay rate of $25.00 per 15 minutes. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, even if I am called to testify by another party, at my then current rates per hour of time. I do not, however, become involved in child custody matters. **BILLING AND PAYMENTS:** You will be expected to pay for each psychotherapy session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Please refer to the Credit/Debit Card Payment Agreement form for detailed information about how outstanding balances are charged. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. **INSURANCE REIMBURSEMENT:** In order 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 (behavioral) health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental (behavioral) health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental (behavioral) health services. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. It may be necessary to seek approval for more therapy after a certain number of sessions. You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to 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. I will provide you with a copy of any report I submit, if you request it. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above. **OFFICE HOURS:** Psychology Wellness Practice, PLLC. is open Monday through Friday. If the South Colonie Central School District has a delayed opening or dismisses early, our office conducts business as usual. If the South Colonie School district has a snow day, myself or my secretary will contact you to discuss your scheduled appointment. **CONTACTING ME:** I am often not immediately available by telephone. When I am unavailable, the office telephone is answered by voice mail or by one of our secretaries. I will make every effort to return your call as soon as it is retrieved, with the exception of weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychiatrist/psychologist on call. If I will be unavailable for an extended time, I will provide you with the contact information for my supervisor, Dr. Jennifer Smitkin. **ELECTRONIC COMMUNICATIONS:** Various types of electronic communications are common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law. ***Email Communications:*** I use email communication only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication. ***Text Messaging:*** Since text messaging is a very unsecure and impersonal mode of communication, I do not text message to nor do I respond to text messages from anyone in treatment with me. So, please do not text message me unless we have made other arrangements. ***Social Media:*** I do not communicate with, or contact, any of my patients through social media platforms like Twitter and Facebook. In addition, if I discover that I have

accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you. I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with patients online have a high potential to compromise the professional relationship. **CONFIDENTIALITY:** In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child is being abused, I must file a report with the appropriate state agency. If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action. Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. **Statement of Release by Parent/Guardian to Insurance Company:** I request that payment of authorized insurance benefits be made on my child's behalf to Psychology Wellness Practice, PLLC for services furnished to me by this practitioner. I authorize Psychology Wellness Practice to release medical and psychological information about my child to the applicable insurance company should any information be needed to determine these benefits. By signing this consent, I acknowledge that I have read it and the Notice of Privacy Practices, or that they have been read to me, that I am at least 18 years old (or, if under 18, married or the parent of a child), that I understand the above agreement, and that I am signing this consent voluntarily.

___________________________________ __________________

Parent/Guardian Signature Date

___________________________________ __________________

Witness Signature Date

Informed Consent for On-line/Tele-therapy

This form is designed to allow you to give informed consent for the use of video technology for online therapy. Read it thoroughly for understanding and ensure all of your questions are answered before signing to give consent.

This is to be used in conjunction with, but does not replace, the Informed Consent document that is required of all clients prior to starting therapy services.

I understand that therapy conducted online is technical in nature and that problems may occasionally occur with internet connectivity. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. Any problems with internet availability or connectivity are outside the control of the therapist and the therapist makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, I agree to call my therapist back at: (518) 608-4271.

I AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN COMPUTER AND IN MY OWN PHYSICAL LOCATION. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

Telehealth Link: https://doxy.me/ajanczyk

Consent to Treatment

I, voluntarily agree to receive online therapy services for an assessment, continued care, treatment, or other services and authorize **Psychology Wellness Practice, PLLC and its providers** to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through **Psychology Wellness Practice, PLLC** at any time. By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_________________________________ _________________________________

Patient/Parent or Guardian (if minor) Signature Date

Psychology * Wellness Practice

Credit/Debit Payment Agreement

____ ________________________________

Patient Name **Patient Date of Birth**

__ I authorize Psychology Wellness Practice, PLLC. to keep my signature on file and to charge my Visa, MasterCard, American Express or Discover listed below for DEDUCTIBLE, COINSURANCE, COPAYMENT, OUT OF POCKET COSTS (e.g., late fees, described below; insufficient funds checks and fees; non-covered medical entities, reviewed in the Outpatient Services Contract), and/or LATE CANCELLATION/NO SHOW amounts due on the account of the patient named above. The card(s) may be charged **automatically** after the original time and date of service if payment was not provided at the time of service**. I understand that only cash and check are accepted at the time of service. Note that balances not paid at the time of service will be charged a $10.00 late fee.** I may continue to schedule appointments provided my credit card remains on file, is valid, and additional fees are not accrued.

____

Visa, MasterCard, American Express, Discover (circle One) Card #: ______________________________________

Card Expiration Date: ______/20______ CV (back of card): _ _ _ Billing Zip Code: ___________________

Visa, MasterCard, American Express, Discover (circle One) Card #: ______________________________________

Card Expiration Date: ______/20______ CV (back of card): _ _ _ Billing Zip Code: ___________________

I understand this form is valid unless I cancel this authorization by written notice. If I choose to cancel this form, I assume full responsibility for paying the above named patient charges in full at the time of service or I will make alternative arrangements for payment. I further understand that withdrawal of this authorization OR declination of my credit/Health Saving Account card upon payment processing will affect my ability to schedule appointments and may result in cancellation of future appointments.

____ ______________________________________

Cardholder Name Cardholder's Relationship to Patient

____ ______________________________________

Cardholder Billing Address City, State Zip

____ ______________________________________

Signature of Cardholder Date

Email address (required): ____

____

I have read and agree to the terms of the payment option(s) I have chosen above and acknowledge that I will be provided with a signed copy of this election form.

_________________________________ ____________________________ ___________________

Signature of Patient **Relationship to Patient** **Date**

(Parent/Guardian if Patient is under 18 yrs old)

Staff Initials and Date: ____________________________ **Copy Provided: YES/NO**

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ________________________________, authorize Psychology Wellness Practice, PLLC to release and obtain the health information described below to:

Name	
Contact Info	

This request and authorization applies to only the following protected health information:

____

____

List each purpose or reason for the use or release of the protected health information:

____

____

This authorization shall remain in full effect until the end of our treatment relationship or it will expire 5 years from today, whichever comes first.

I understand that, except with respect to action already taken in reliance on this authorization, I may revoke this authorization in writing at any time by delivering or sending written notification to:

Psychology Wellness Practice, 139 Vly Road, Albany, NY 12205 Email: jsmitkin@pwpractice.com

I understand that Psychology Wellness Practice, PLLC may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is related to the research project.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws. If this authorization is for the release of HIV-related information, the recipient of the information is prohibited from redisclosing any HIV-related information about you without your authorization unless permitted to do so by federal or state law.

I understand that I have the right to receive a copy of this authorization after I have signed it. I understand that a copy of this authorization will be maintained in my patient record.

I understand that I have the right to refuse to sign this authorization.

____ ______________________________

Patient's signature (relationship if signed by parent / guardian) Date

____ ______________________________

Witness signature Date

Social History

I. Family Data

Child's Name:________________________ Today's Date:____________________

Grade:______________________________ Date of Birth:____________________

Age: _______________________________ Home phone:_____________________

Address:____

Person filling out this form:_________________ Relation to child: ________________

Mother's name:_______________________ Occupation_______________________

Home phone: ____________ Business phone:___________ Cell phone:___________

Father's name:________________________ Occupation_______________________

Home phone: ____________ Business phone ___________ Cell phone:___________

Marital status of parents: ____

If parents are separated or divorced, how old was the child when the separation occurred? __________

What is the current custody arrangement?_____________________________________

Is the child adopted ? Yes No If yes, child's age when adopted__________

Please describe any specific information about the adoption (e.g., significant events prior to adoption, etc.)

____

List all people living in the household:

Name Relationship to child Age

____
____
____
____

If any brothers or sisters are living outside the home, list their names and ages:________________

Primary language spoken in the home:_________________________________

Below, please specify family members (e.g., child's sister, maternal aunt, paternal grandmother) that have experienced any of the following:

	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Difficulties learning to read					
Difficulties in math					
Difficulties in writing					
Depression					
Anxiety					
Attentional Difficulties					
Hyperactivity					
Emotional/behavior Problems					
Autism					

II. Presenting Problem

Please list your child's current diagnoses, if any. ____

Diagnosis	Date Diagnosed	Physician/Psychologist who made Diagnosis

Briefly describe your child's current difficulties: ____

____

How long has this problem been of concern to you? ______________________________________

What do you believe to be the primary issues contributing to those difficulties?___________________

____

What has been done to address the problem?

At home?____

At school?____

Has the child received evaluation or intervention/counseling services for the current problem or similar problems? Yes No

If yes, when and with whom? ____

III. Developmental History

Were there any prenatal difficulties? Yes No If yes, please describe ______________________

Were forceps used during delivery? Yes No

Was a Caesarean section performed? Yes No If yes, for what reason? ____________________

Was the child premature? Yes No If so, by how many months? __________________________

What was the child's birth weight? ____

Were there any birth defects or complications? Yes No If yes, please describe:_______________

Were there any special problems in the growth and development of the child during the first few years?

Yes No If yes, please describe:____

To your knowledge, at approximately what age did your child attain the following developmental milestones?

Spoke single words________________________ Said short sentences (2 to 3 words)______________________

Walked without assistance___________________ Became toilet trained______________________________

What disciplinary techniques do you find to be successful with your child?_________________________

____

____

IV. Medical History

Place a check next to any health problems that the child has had or has now. When you check an item, also note the approximate age at which the child developed the illness.

Condition	√	Age	Condition	√	Age
High Fever			Eye/Vision Difficulties		
Recurrent Ear Infections			Speech Problems		
Seizures			Allergies		
Head Injury			Asthma		
Loss of Consciousness			Headaches		

Is the child on any medication at this time? Yes No

If yes, please note kind of medication: ____

Is your child generally in good health? Yes No If no, please explain___________________________________

Has your child ever had a serious illness, been hospitalized, or had surgery? Yes No

If yes, please explain:____

Name of child's Primary Care Physician_________________________________ Phone:___________________________

Date of child's last physical exam:_________ Did exam reveal normal results? Yes No

If no, please explain:____

Does your child require the use of glasses/contacts? Yes No

V. Social and Behavior Checklist

Directions: Please place a checkmark to indicate which issues apply to your child at this time.

__Depression	__Communication Difficulties
__Suicidal thoughts or actions	__Low Self-Esteem
__Anxious/Worried	__Issues related to custody/visitation
__Moody/Sad	__Victim of sexual abuse
__Panic Attacks or Intense Fears	__Domestic violence (verbal, physical, threats)
__Anger Problems, quick temper	__Conduct Problems, in trouble with the law
__Physically fighting with others	__Eating Disorder Symptoms
__Outbursts or Explosive Behavior	__Family Problems
__Alcohol/other drug abuse	__Parent Drug/Alcohol abuse
__Behavioral difficulties in school	__Academic difficulties in school
__School Problems __Truancy or School Avoidance	__Family Problems __Conflicts with mother

__Suspensions or Expulsion __Learning Disabilities __Problems with attention __Lack of work completion at school __Lack of homework completion __Not listening to teacher __Fighting at school __Victim of bullying __Demonstrates bullying behavior	__Conflicts with father __Conflicts with step-parent __Parents having marital problems __Problems with brother/sister __Running away from home __Disobedient __Verbal Aggression __Physical Aggression __Domestic violence
__Death of a loved one	__Toileting Accidents
__Major losses/difficult changes	__Fire Setting
__Frequent stealing, lying, cheating	__Shy, clingy, wants to be with parents
__Very active, possibly hyperactive	__Sleep Difficulties
__Problems with Friends	__Doesn't think before acting
__Does not appear sorry for actions	__Does cruel or strange things
__Bangs head	__Easily frustrated
__Cuts or burns self	__Other:

Sources of Stress:

Please list any things/events/problems that are creating stress in your child's and/or your family's lives at the present time (include significant losses and changes). If none, please indicate that.

____

____

____

____

VI. Relationships:

Please use a checkmark to indicate which statements apply to your child at this time.

__Too few friends	__Enough friends
__Friends are part of support system	__Doesn't share problems with friends
__Overly Shy	__Finds it difficult to open up to others
__Makes friends easily	__Finds it hard to keep friends
__Spends time with peers of a similar age	__Prefers younger companions
__Prefers older companions	__Is susceptible to peer influence
__Is a leader among friends	__Friends are a negative influence

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VII. Educational History

Please list all schools that your child has attended, including preschool and nursery school experiences.

Name of School **Location/District** **Dates Attended/Grades Completed**

____
____
____
____

Has your child ever repeated a grade? Yes No If yes, what grade and why? ____________________
Has your child ever had an Individualized Education Plan?

Has your child ever received special tutoring or therapy in school? Yes No

If so, please indicate below:
___Remedial Reading ___Speech Therapy ___Occupational Therapy
___ Physical Therapy ___Counseling Services ___Behavioral Supports

What are your child's assets or strengths? ______________________________
____

Is there any other information that you think may help us in working with your child?

Date:____________ Signature: ____________________

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. If you have any questions about this notice please contact the Privacy Contact who is: Andrea Janczyk, LMHC

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by your physician to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician. Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. **Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. **Uses and Disclosures of Protected Health Information Based upon Your Written Authorization**

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. **Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object** We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed. **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected 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. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care. **Emergencies:** We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you. **Communication Barriers:** We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances. **Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object** We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include: Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures. Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws. Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim

of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws. Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required. Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process. Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the even that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred. Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual. Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized. Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs. Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq. 2. Your Rights Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights. You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact. **You may have the right to have your physician amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record. **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. **Complaints** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.