Joseph WILNER, LCP
Clinical Psychotherapist and Coach
9401 Indian Creek Pkwy, Suite 1030
Overland Park, KS 66210

**Child & Adolescent Psychosocial Assessment**

Client Name: _____ Client Age: _____

PRESENTING PROBLEM: (Briefly describe the issues/problems which led to your decision to seek therapy/counseling services.)

_____
_____
_____
_____

**Symptom Check List** Are you currently experiencing any of the following issues?

| Symptom | Onset | Description |
|---|---|---|
| Problems sleeping? | | |
| Eating too much or too little? | | |
| Weight gain or loss in lbs.? | | |
| Loss of interest in things you used to enjoy? | | |
| Inability to function at home or at work? | | |
| Sad, bored or depressed? | | |
| Feeling tired? | | |
| Angry, grouchy or irritable? | | |
| Poor focus or concentration? | | |
| Memory problems? | | |
| Racing thoughts? | | |
| Rapid speech? | | |
| Thoughts of hurting yourself? | | |
| Thoughts of hurting others? | | |

| | | |
|---|---|---|
| Self-injurious behaviors (i.e. cutting, scratching, pulling hair out)? | | |
| Feeling anxious or panicked? | | |
| Mood swings (i.e. depressed, manic, anxious, euphoric, insomnia)? | | |
| Poor Impulse Control (ex: spending, sex, gambling)? | | |
| Having memories of traumatic events? | | |
| Phobias, fears, worries? | | |
| Auditory or visual hallucinations? | | |
| Strange of unusual ideas or beliefs? | | |
| Repetitive thoughts/behaviors (ex: obsessions, hand washing)? | | |
| Thoughts that others want to hurt you? | | |
| Questions about your sexual orientation? | | |
| Problems with body image? | | |

Suicidal/Homicidal Ideation:
Have you ever attempted to commit suicide or homicide in the past? _____
If yes, how?_____
Is there a history of suicide in your nuclear and/or extended family? _____
Have you ever inflicted burns and/or wounds on yourself? _____
Are you presently suicidal/homicidal? _____

Recent Losses: (Please check all that apply)

- Family _____
- Health _____
- Disruption in lifestyle _____
- Job _____
- Significant other _____

Other: _____

Any Pending Civil or Criminal Litigation/Lawsuits/Divorce or Custody Disputes? (If yes, please explain)
_____
_____
_____

Probation Officer's Name: _____

MEDICAL ISSUES:

| **Illness or other medical concerns:** | **When did this problem begin?** | **Treating Doctor & Phone Number** |
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| Medication | Dosage | Frequency | Prescribed by | Reason for taking |
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| **ALLERGIES** |
|---|
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PSYCHIATRIC/PSYCHOLOGIAL HISTORY: (please include all previous therapists and hospitalizations or in-patient treatment facilities)

| **Name of Provider / Hospital** | **Reason** | **Length of Treatment** |
|---|---|---|
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Name of current psychiatrist and contact information

_____

Name phone

Current primary physician and facility:

_____

Name Facility Phone

SUPPORT SYSTEM

Who can you count on for support? (Check all that apply)

- Parents
- Spouse
- Siblings
- Employer
- Church
- Therapist
- Neighbor
- Extended Family
- Close Friend
- Self Help
- Group
- Community Services
- Co-Worker
- Medical Doctor

**Additional support systems (please describe any groups, hobbies, or activities that you participate in or have interest in.**

_____

_____

_____

_____

**Occupational**

| Employer | Length of Employment | Describe Any Job Stressors | Describe Any Potential or Pending Disciplinary Actions |
|---|---|---|---|
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Family Composition/Environment:
Please list names, ages, relationships and other relevant information regarding the immediate family whether living in- or outside the home. In blended families, please include child/parent and child/sibling relationships.

| Name | Sex: M/F | Age | Marital Status | Relation to client | Currently Residing | Describe Relationship | Occupation |
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Relationship History:

| **Partner's Name & Age / Your Age. Begin with your first sexual experience.** | **Length of Relationship** | **Reason Relationship Ended Or Current State of The Relationship** | **Was There Verbal Abuse and/or Domestic Violence (Pushing, Pinching, Threatening, Hitting)** | **How Many Episodes of Verbal Abuse or Domestic Violence Occurred? Were police involved?** |
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**<u>Family History of Mental Illness, Alcoholism or Substance Use</u>**

| How the person is related to you | Name of this family member | Type of Mental Illness | Alcoholism | Substance Used |
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Comments regarding family:

_____

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**Trauma History** Have you ever experienced any of the following events?

| Nature of Trauma | How old was client? | How much has this impacted you the last year? | Please Describe What Happened |
|---|---|---|---|
| Childhood Neglect | | | |
| Verbal Abuse | | | |
| Physical Abuse | | | |
| Sexual Abuse | | | |
| Divorce of Parents | | | |
| Death of Love One | | | |
| Rape | | | |
| Domestic Violence | | | |
| Physical Assault | | | |

| | | | |
|---|---|---|---|
| Community Violence | | | |
| Being Bullied | | | |
| Stalking | | | |
| Life Threatening Illness | | | |
| Onset of Chronic Illness | | | |
| Natural Disaster | | | |
| Violent Behavior | | | |
| Transportation Accident | | | |
| Other | | | |

DRUG/ALCOHOL ASSESSMENT

SUBSTANCE USE HISTORY

(include experimentation & accidental ingestion. Include alcohol, tobacco, and caffeine)

| Drug | Method | Age 1st used | Age last used | Onset of heavy use | # Days used in last 30 | Amount used in last 48 hours | Last used when? | Drug of choice? Y/N | How much does this impact your daily functioning? |
|---|---|---|---|---|---|---|---|---|---|
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Any changes in patterns of use over time? □Yes □No
Does individual ever drink more than he/she intends? □Yes □No
Has individual experienced an increase in the amount he/she can use to get the same effect? □Yes □No
Is there a history of overdoes? □Yes □No
Is there a history of seizures? □Yes □No
Is there a history of blackouts? □Yes □No
Has individual ever used medications to either get high or come down from being high? □Yes □No
With whom does individual usually use? □Yes □No
Has individual had previous substance abuse treatment? □Yes □No
Assessment of risk in this area:

_____

_____

Developmental History (if client is under 18) (to be filled out by parent)

Any complications during pregnancy? □Yes □No _____
Any complications during delivery? □Yes □No _____
Did mother receive prenatal care? □Yes □No
Did mother smoke or drink during pregnancy? □Yes □No _____
Any traumatic events occur during pregnancy? □Yes □No _____
Was the child hospitalized after birth? □Yes □No _____
Age walking? _____ Age talking? _____ Age toilet trained? _____

How active as baby? _____
What was child's disposition like as a small child? _____
Does your child have and make friends easily? □Yes □No _____
Sleep Patterns:
Bedtime: _____ Wake up: _____ Where does child sleep: _____
Does child wake up often at night? □Yes □No _____
Does child have nightmares/night terrors? □Yes □No _____
Describe bedtime routine: _____

_____
Does child have chores in the home? □Yes □No _____

Personality of Child: (shy, restless, overactive, withdrawn, outgoing, timid, athletic, etc…)

_____

_____
Describe some strengths of your child:

_____

_____
Describe areas of weakness or difficulties your child has:

_____
_____

EDUCATION:
Highest grade completed _____
Current school (if applicable) _____
Does the client have any diagnosed learning disabilities? □Yes □No If Yes please describe:
_____
_____
_____
Does the child have an IEP or 504? □Yes □No _____
What is the client's achievement and attitude toward school/education?
_____
_____
Discipline Issues: _____
_____
_____
Additional Comments regarding your child:
_____
_____
CLIENT STRENGTHS/WEAKNESSES
In your opinion, what are your strengths?
_____
_____
_____

In your opinion, what are your limitations?
_____
_____
_____

**Your Goals for Therapy**

Can you describe any of the goals you would like to work toward in therapy. Your answer will help us to work together to develop an effective treatment plan for you.

| Your Goals: | Time Line: |
|---|---|
| 1) | |
| 2) | |
| 3) | |
| Your Strengths: | |
| | |

| What makes you happy? |
| --- |
| |
| What are your most important hopes/dreams? |
| |
| What are you most distressed over now? |
| |
| Areas you want to work on improving: |
| |

Individual completing assessment:

Printed Name _____ Signature _____

Parent Printed Name _____ Parent Signature _____

Relationship: _____

Joseph
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# Office Policies & Informed Consent for Treatment

**Charges:** The 60-minute session charge is $125.00. The client shall pay this fee at the time of the session unless other payment or insurance arrangements have been made with the therapist prior to session. **Telephone conversations, site visits, report writing and reading, consultation with other professionals, reading records, longer sessions, travel time, etc. will be charged at the same rate.** Please notify Joseph Wilner if any problem arises during the course of therapy regarding your ability to make timely payments. The client is responsible to make co-payments at the beginning of each session. Any amounts not covered by client's insurance, including deductibles, non-covered services, or claims which exceed covered benefit amount, will be the sole responsibility of the client to pay upon receipt of invoice which will be provided by Therapist. Initial _____

**Cancellations:** Cancellations may be made 24 hours in advance of the scheduled session time with no cancellation charge to client. Scheduling an appointment involves the reservation of time specifically for you. **A fee of $125 will be charged for sessions missed without such notification unless you have a medical emergency**. Most insurance companies do not reimburse for missed sessions. Joseph Wilner will hold your appointment time for 15min past the hour. **If you are more than 15 min late or you do not show up for your appointment, your appointment will be cancelled and you will be charged the no-show rate of $125, unless you have made arraignments with Joseph Wilner.** Initial _____

**Additional Sessions:** Optimal scheduling for psychotherapy sessions is once each week. Additional weekly sessions may be arranged if a client is in crisis, or on an as needed basis.

**Letters:** Any request for written documentation from Joseph Wilner, LCP must be provided in writing and is subject to 2 week turn around. A fee of $15 must also be paid before the document is provided. Initial _____

**Qualifications:** I am a Licensed Clinical Psychotherapist and my license number is 1485. I hold a Master's Degree in Counseling Psychology. I have over 10 years of clinical experience working in an out-patient setting serving individuals, youth, and families.

I have specialized training in Cognitive-Behavior Therapy (CBT), Acceptance and Commitment Therapy (ACT), and Mindfulness-based Interventions (MBI). I have specific experience working with individuals, youth, and families around the following areas: depression, anxiety, stress-management, career planning, and attention-deficit/hyperactivity Disorder (ADHD)

**Confidentiality and Privilege:** All information disclosed within sessions and the written 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. Most of the provisions explaining

when the law requires disclosure were described to you in the Notice of Privacy Practices that you received with this form.

**When Disclosure is required by law**: Some of the circumstances where disclosure is required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; and where a client presents a danger to self, to others, to property, or is gravely disabled (for more details see also Notice of Privacy Practices form).

**When disclosure may be required:** When disclosure may be required pursuant to a legal proceeding if you place your mental health status as an issue in litigation by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Joseph R. Wilner. Joseph R. Wilner will not release records to any outside party unless she is authorized to do so by all adult family members who were part of the treatment.

**Health insurance & confidentiality of records**: Disclosure of confidential information may be required by your health insurance carrier of HMO/PPP/MCO/EAP in order to process the claims. If you so instruct, only the minimum necessary information will be communicated to your insurance carrier. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. *(Please see Insurance Consent form)*

**Confidentiality of E-mail, cell phone, and faxes communication:** It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. Please notify Joseph R. Wilner at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above mentioned communication devices. Please do not use e-mail or faxes, or text messages for emergencies.

**Litigation Limitations:** 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, law suits, etc.), **neither you nor your attorney, nor anyone else acting on your behalf will call on Joseph R. Wilner to testify in court or at any other proceedings, nor will a disclosure of the psychotherapy records be requested. If at any time Joseph R. Wilner is subpoenaed to appear in court you will be responsible for the full fee of $150 per hour including drive time and any legal or documentation fees incurred.** Initial _____

**Emergencies:** If there is an emergency during our work together, or in the future after termination, where Joseph R. Wilner becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, he 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, he may also contact the emergency contact person whose name you provided on the information sheet. In the event of a life-threatening emergency, please call 911 immediately. If there is an emergency that is not life-threatening please call Joseph R. Wilner at (913) 444-9750.

**Voluntary Participation:** Clients voluntarily agree to psychotherapy and can terminate treatment at any time. A client may derive the greatest benefit from psychotherapy when they can commit to engaging in the therapeutic process on a weekly basis for a minimum of 10 weeks.

Often, longer-term therapy is indicated. Establishing goals for treatment are helpful in designing an appropriate treatment plan.

**Outcomes:** Therapists may not guarantee outcomes or results from psychotherapy.

**Risks Associated with Counseling:** By its nature, psychotherapy is an exploratory process that may at times evoke uncomfortable feelings, anxiety, emotional pain, sorrow, or painful memories. It is the goal of the therapist to assist the client in coming to terms with difficult material while acquiring coping skills to manage difficult feelings.

**Orientation:** During the course of therapy Joseph R. Wilner 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 may include: mindfulness based, trauma informed, attachment based, behavioral, cognitive- behavioral, psychodynamic, existential, family systems, developmental (adult, family, child) and psycho-educational.

**Discussion of Treatment Plan:** Within a reasonable period of time after the initiation of treatment, Joseph R. Wilner will discuss with you him 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, Joseph R. Wilner'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 that Joseph R. Wilner does not provide, he has an ethical obligation to assist you in obtaining those treatments.

**Colleague Consultation:** In keeping with generally accepted standards of practice, Joseph R. Wilner may consult with other mental health professionals regarding the management of the cases. The purpose of consultation is to ensure quality of care. Every effort is made to strictly protect the identity of clients. Client's name or identifying information is never mentioned.

**Ethical Guidelines:** Master Level Psychologist ethical guidelines are defined by the American Psychological Association (APA). These guidelines are available online.

**Mediation and Arbitration:** All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before and as pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of Joseph R. Wilner and the client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Johnson County, in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue, (unpaid) and there is no agreement on a payment plan, Joseph R. Wilner can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorney's fees. In the case of arbitration, the arbitrator will determine the sum.

**Termination:** As set forth above, after the first couple of meetings, Joseph R. Wilner will assess if he can be of benefit to you. Joseph R. Wilner does not accept clients who, in his opinion, he cannot help. In such a case, he will give you a number of referrals that you can contact. If at any point during psychotherapy, Joseph R. Wilner assesses that he is not effective in helping

you reach the therapeutic goals, he is obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, she would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, Joseph R. Wilner 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, Joseph R. Wilner will assist you in finding someone qualified, and if he has your written consent, he will provide her or him with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, Joseph R. Wilner will offer to provide you with names of other qualified professionals whose services you might prefer.

**Dual relationships:** Not all dual relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs your therapist's objectivity, clinical judgment, or therapeutic effectiveness or can be exploitative in nature. Johnson County is a small community and many clients know each other and Joseph R. Wilner from the community. Consequently, you may bump into someone you know in the waiting area or Joseph R. Wilner out in the community. Joseph R. Wilner will never acknowledge working therapeutically with anyone without his/her written permission.

I understand and agree to the terms of this informed consent as indicated by my signature on the following page.

**Consent for Treatment**
**I, the undersigned, do hereby agree and give my consent for Joseph R. Wilner, MA, LCP to provide mental health treatment considered necessary and proper in diagnosing and treating my condition.**

| **Signature** | **Relationship to Patient** | **Date** |
|---|---|---|
| **Signature** | **Relationship to Patient** | **Date** |
| **Signature** | **Relationship to Patient** | **Date** |

_____
Witness Date

# Client Information Sheet

Client Name: _____ Parent or Guardian: _____

Current Address (cannot be PO box): _____

Gender: ___ DOB: _____ Who Referred You? _____

Mobile #: _____ Work/Alternate #:_____

Home #: _____ Parent Phone#: _____

E-mail(s):_____

Emergency contact or next of kin: (Optional)_____

**If using insurance, please fill out the following section:**

Insurance:_____ Policy #: _____

Name of Insured: _____ DOB: _____

Clients DOB and relation to insured if different: _____

Copay/Coinsurance/Deductible: _____

Secondary Insurance Info if Applicable: _____

Please initial your response to the following questions:

***May I have your consent/permission to:***

Contact you by email? Yes___ No___

Contact you by phone? Yes___ No___
If yes, which number is best to reach you _____

Leave a voice message on your phone? Yes___ No___

Text you? Yes___ No___

I hereby provide my consent regarding means of communication and contact with my therapist. I have had a chance to have any questions or concerns answered by my therapist.

Signature(s) Date

**ACKNOWLEDGMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICES**

I received from Joseph Wilner, LCP a written copy of Notice of Privacy Practices. I understand that this Notice of Privacy Practices explains how Joseph Wilner, LCP may use and disclose my protected health information, as well as my rights, and therapist obligations with respect to that information.

| Print Name (Client) | Signature | Date |
|---|---|---|

| Print Name (Client) | Signature | Date |
|---|---|---|

| Print Name (Responsible Adult) | Signature | Date |
|---|---|---|

Joseph WILNER
9401 Indian Creek Pkwy, Suite 1030
Overland Park, KS 66210
(913) 444-9750

# Credit/Debit Card Authorization

Card Type (circle): Visa MasterCard Discover American Express

Name on Card: _____

Card Number: _____

Expiration: _____ CVV: _____ Billing Zip Code: _____

I hereby provide my consent for Joseph Wilner, LCP, to charge this card for payment of therapy sessions, cancellations within 24 hours of the appointment, and missed appointments.

_____

Signature Date

**Joe Wilner, MA, LCP**
Licensed Clinical Psychotherapist
9401 Indian Creek Pkwy
Overland Park, Kansas 66210
P: 913.444.9750
info@joewilner.com

# AUTHORIZATION & REQUEST FOR RELEASE OF CONFIDENTIAL INFORMATION AND PRIVILEGED COMMUNICATION

In accord with my legal right to confidentiality and privileged communication relevant to the services that I have received, I authorize request

□ The disclosure of confidential information from the files of Joe R. Wilner, LCP
□ Confidential information to be released by the following individual(s) to Joe R. Wilner, LCP

Agency/Name: _____Phone #: _____
Address:_____
Street City Zip

□ Summary report of services received
□ Consultation and/or verbal communication between the above named parties
□ Any and all records pertaining to services received
□ Other _____

It is my understanding that this information will be used for _____
_____

This consent expires _____, unless revoked by me in writing at an earlier time.

I issue this authorization with knowledge of the contents, as checked above, of the material or communications involved and with an understanding of the consequences. I issue this authorization voluntarily and free from duress of undue influence.

In accordance with federal regulations (42 CFR Part 2), which prohibits any further disclosure of this information, except with specific written consent of the person to whom it pertains, re-disclosure of this information is prohibited.

I agree to pay a reasonable fee, if any, for the preparation of the materials and hereby hold harmless the above named practitioner from any liability relevant to the release of the confidentiality information or privileged communication.

Authorizing Signature _____ Date _____

Authorizing Signature _____ Date _____

Name of Client/Family _____ Date _____

Address: _____
Street City Zip

# NOTICE OF PRIVACY PRACTICES

**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.**

I am required by law to maintain the privacy and security of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice"). I must abide by the terms of this Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

Except for the specific purposes set forth below, I will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving me written notice of your revocation.

**Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent**. I can use and disclose your PHI without your Authorization for the following reasons:

1. **For your treatment**. I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist, I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me an Authorization to do so.

2. **To obtain payment for your treatment**. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company to get paid for the health care services that I have provided to you, although my preference is for you to give me an Authorization to do so.

3. **For health care operations**. I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

**Certain Uses and Disclosures Require Your Authorization**.

1. **Psychotherapy Notes**. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

    a. For my use in treating you.

b. For my use in training or supervising other mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
c. For my use in defending myself in legal proceedings instituted by you.
d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
e. Required by law, and the use or disclosure is limited to the requirements of such law.
f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
g. Required by a coroner who is performing duties authorized by law.
h. Required to help avert a serious threat to the health and safety of others.

2. **Marketing Purposes**. As a psychotherapist, I will not use or disclose your PHI for marketing purposes**.**

3. **Sale of PHI**. As a psychotherapist, I will not sell your PHI in the regular course of my business.

**Certain Uses and Disclosures Do Not Require Your Authorization**. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received

another form of therapy for the same condition.

8. Specialized government functions, including**,** ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

**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 person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

**YOUR RIGHTS YOUR REGARDING YOUR PHI**
You have the following rights with respect to your PHI:

1. **The Right to Request Limits on Uses and Disclosures of Your PHI**. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say “no” if I believe it would affect your health care.

2. **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full.** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. **The Right to Choose How I Send PHI to You**. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. **The Right to See and Get Copies of Your PHI**. Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you.

   I will provide you with a copy of your record, or a summary of it, if you agree

to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.

5. **The Right to Get a List of the Disclosures I Have Made**.
   You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization.

   I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. **The Right to Correct or Update Your PHI**. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

7. **The Right to Get a Paper or Electronic Copy of this Notice**. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

**HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES**
If you think I may have violated your privacy rights, you may file a complaint with me, as the Privacy Officer for my practice, and my address and phone number are:
_____.

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

1. Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;
2. Calling 1-877-696-6775; or,
3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

I will not retaliate against you if you file a complaint about my privacy practices.

**EFFECTIVE DATE OF THIS NOTICE**
This notice went into effect on September 20, 2013.