ELIZABETHTOWN PARTNERS IN COUNSELING
CLIENT REGISTRATION FORM

OFFICAL USE ONLY
DIAGNOSIS CODE:_____

TODAY'S DATE_____

CLIENT NAME_____
Last First Middle

ADDRESS _____

CITY_____STATE _____ZIP _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

HOME PH_____ CELL PH_____ Email _____

ARE MESSAGES OK? (Circle all that apply): voice text email ETHNICITY _____

MARITAL STATUS (circle one): single married widow separated divorced

EMPLOYER _____EMPLOYER PH # _____

EMERGENCY CONTACT_____PHONE #_____

PERSON RESPONSIBLE FOR FINANCIAL OBLIGATION

NAME_____RELATIONSHIP TO CLIENT_____

ADDRESS_____CITY_____

STATE _____ZIP _____PHONE _____

INSURANCE INFORMATION

POLICYHOLDER_____RELATIONSHIP TO CLIENT _____

POLICYHOLDER DOB_____POLICY # _____GROUP# _____

PRIMARY INSURANCE CO _____ADDRESS_____

VERIFICATION PHONE # _____POLICY HOLDER EMPLOYER_____

SOCIAL SECURITY # OF POLICYHOLDER_____

SECONDARY INSURANCE

POLICYHOLDER_____RELATIONSHIP TO CLIENT _____

POLICYHOLDER DOB _____POLICY# _____GROUP# _____

SECONDARY INSURANCE CO. _____ADDRESS _____

VERIFICATION PHONE # _____POLICYHOLDER EMPLOYER_____

ELIZABETHTOWN PARTNERS IN COUNSELING, INC. CONFIDENTIAL

RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

For the purpose of securing payment of benefits/services under my insurance plan/coverage, I hereby consent to authorize Elizabethtown Partners in Counseling to release any and all pertinent information about my diagnosis and services, or my child's (if a minor) to my insurance carrier or agency that is responsible for certifying and reviewing the need for continued services.

_____ _____ _____

Signature of Client/Parent/Guardian Relationship to Client Date

INFORMED CONSENT

I understand that I am eligible to receive a range of services with Elizabethtown Partners in Counseling. The type and extent of services will be determined following an initial assessment and discussion with me. The goal of the assessment process is to determine the best course of treatment. Typically, treatment is provided over the course of several weeks.

I understand that all information is confidential, and no information will be released without my consent and written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include: A) when there is risk of imminent danger to myself or another person, the clinician is ethically bound to take necessary steps to prevent such danger; B) when there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities; C) when a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that while psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects.

If I have any questions regarding this consent or about the services, I may discuss them with my therapist. I have read and understand the above and consent to participate in treatment/give my permission for treatment for myself (or my child if a minor). I understand that I may stop treatment at any time.

_____ _____ _____

Signature of Client/Parent/Guardian *Relationship to Client* *Date*

ELIZABETHTOWN PARTNERS IN COUNSELING
204 NORTH MAIN STREET
ELIZABETHTOWN, KY 42701
PHONE: 270-360-1222 FAX: 270-360-0333

MEDICAL HISTORY

NAME:_____ FAMILY DOCTOR:_____

WEIGHT:_____ HEIGHT:_____ AGE:_____ OTHER DOCTORS:_____

1. Current physical/health problems: _____

_____

_____

2. Current Medications: _____

_____

_____

3. Check any of the following problems you have experienced or are currently experiencing:

____ High Blood Pressure

____ Diabetes

____ Kidney Problems

____ Liver Problems

____ Bone/Joint Problems

____ Stomach/Colon Problems

____ Seizures

____ Headaches

____ Cancer

____ Hormone Problems

____ Food Binges

____ Fasting

____ Lung/Breathing Problems

____ Weight Gain/Loss

____ Depression/Irritability

____ Disease of Reproductive Organs

4. Allergies to food/medication/environment:_____

_____

_____

5. Medical/Surgical/Hospitalizations an dates: _____

_____

_____

6. Outpatient counseling/mental health treatments and dates: _____

_____

_____

7. Special Diets: _____

_____

_____

8. Substance Abuse (alcohol, nicotine, laxatives, other) Please describe: _____

_____

_____

_____

9, Other Important Information: _____

_____

_____

_____

CONFIDENTIAL COMMUNICATIONS – ALTERNATIVE CONTACTS:

DATE:_____

PATIENT NAME:_____

May we send mail to your home address? YES NO

Alternative address to use if you do NOT want mail sent to your home:_____

_____

Phone Numbers:

	OK TO CALL?		LEAVE MSG?	
Home:_____	Y	N	Y	N
Work:_____	Y	N	Y	N
Cell:_____	Y	N	Y	N
Other:_____	Y	N	Y	N

_____ _____

Signature of Patient/Representative date

_____

Relationship if Representative

Attention

Please be advised that we do not accept **any** cases involved in litigation, court ordered treatment, child custody, workers compensation, etc. An initial appointment does not guarantee continued services. If we discover that court is involved, you will likely be referred to alternate services that do accept court cases.

Thank You,
Elizabethtown Partners In Counseling

All No Show and Late Cancellation's
(Less than 24 hour notice)
will be subject to a $50.00 fee which is
non-billable to insurance. This includes initial appointments.

NO EXCEPTIONS WILL BE MADE

We attempt to contact all patients by phone the day before any scheduled appointment. A message will be left stating date and time of appointment. Not receiving a reminder message will not justify a missed appointment.

It is the patient's responsibility to keep an accurate account of their appointments.

Failure to pay fees (no show, late cancel, deductibles, or co-pays will result in inability to schedule future appointments or receive medications or prescriptions.

Patients Financial Responsibilities

I,_____ agree to be responsible for any copay's, deductibles, or any accrued charges that my insurance company has not covered. If I do not carry health insurance, I agree to be responsible for the cost of services provided to me. I am aware that if I neglect to pay the assumed charges, I will be denied further service, and my account will be turned over to a collection agency. Once the account has been paid in full, I will once again be eligible for treatment.

I have read and understand the Elizabethtown Partners in Counseling financial policy. I agree to assign insurance benefits to Elizabethtown Partners in Counseling, whenever necessary. I also agree that if it become necessary to forward my account to a collection agency, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency for costs of collections. Also all attorney/lawyer fees, reasonable interest and court costs incurred should they become necessary, are to be reimbursed by the patient. I agree to pay all charges.

Signature_____

Date _____

Patient: By signing this form you agree to all the above mentioned conditions, and to be contacted by auto caller at your home or by cell phone if necessary. They may also contact your by sending text messages or E-mail, using any E-mail address you provide to us. These terms and conditions will remain in effect until your treatment is deemed no longer necessary, or until the final payment for services has been received.

Elizabethtown Partners In Counseling, Inc.

Client Rights and Responsibilities

Elizabethtown Partners In Counseling clients have the right:

- To know their rights and responsibilities in the treatment process.
- To be treated with dignity and respect.
- To have their treatment and other client information kept private.
- To have their records released only with client's permission unless it is an emergency or required by law.
- To information from staff/providers in a language they can understand.
- To have an easy to understand explanation of their condition and treatment.
- To know about all their treatment choices, regardless of cost or insurance coverage.
- To get information about provider's services and role in the treatment process.
- To information about provider's.
- To know the clinical guidelines used in providing and/or managing their care.
- To provide input on provider's policies and services.
- To know about state and federal laws that relate to their rights and responsibilities.
- To share in the formation of their plan of care.
- To fair treatment regardless of race, religion, gender ethnicity, age, disability, or source of payment.

I have read and understand all of the above statements.

Printed Name	Signature	Date

Relationship to Patient

ELIZABETHTOWN PARTNERS IN COUNSELING

PRIVACY POLICY AND OFFICE POLICIES

PATIENT:_____

GIVEN TO/MAILED TO ON_____

I AFFIRM RECEIPT OF THE ABOVE POLICIES

_____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

Elizabethtown Partners In Counseling

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I HEREBY REQUEST A COPY OF THE FOLLOWING PATIENT'S MEDICAL RECORD:

FULL NAME OF PATIENT: _____

MAIDEN NAME/ALIAS: _____ PATIENTS BIRTH DATE: _____ S.S.N. _____

INFORMATION REQUESTED (X): ( ) COMPLETE MEDICAL RECORD ( ) PORTION OF MEDICAL RECORD*

* If only a portion of the medical record is required please specify:

( ) Inpatient/Outpatient treatment records ( ) Admission/discharge summaries ( ) Academic summaries ( ) Progress notes

( ) Diagnosis/prognosis/recommendations ( ) Psychological/psychiatric summaries ( ) Social/ family/ educational assessments ( ) Other

INFORMATION REQUESTED FROM/TO:

Provider/Facility: ELIZABETHTOWN PARTNERS IN COUNSELING

Street Address: 204 North Main Street City/State/Zip: Elizabethtown, KY 42701

Phone number: 270-360-1222 Fax Number: 270-360-0333

THE ABOVE INFORMATION IS TO BE RELEASED TO/FROM:

Name/Facility _____

Street Address _____

City/State/Zip _____ Fax Number _____

THIS RECORD IS REQUESTED FOR THE FOLLOWING REASON (X)

( ) To facilitate treatment ( ) To coordinate medical care ( ) To provide follow up information ( ) To provide info to the court

( ) For interagency coordination of care/case management ( ) Other

The authorization must be signed and dated and may be revoked by notifying the Elizabethtown Partners In Counseling office mentioned above in writing at any time except to the extent action has been taken prior to revocation. This consent will expire 1 year after the date below or sooner by my choice, in which case this consent will expire on this date or event _____. Such expiration date or event has not occurred.

REQUEST FOR RECORD COPY RELEASE WILL BE HANDLED ON A FIRST COME FIRST SERVE BASIS.

( ) Kentucky law directs health care providers to furnish to a patient, at the patient's request, one free copy of the patient's Medical Record.

I understand that the medical record released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by federal and/or state law. Federal and state regulations prohibits you (the recipient) from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Signature: _____ Date: _____
Patient, Parent, or Legally Authorized Representative

FOR INTERNAL OFFICE USE ONLY:

Date Authorization Received: _____ Date Records Sent: _____ Initials: _____

PCP/BH PROVIDER COMMUNICATION FORM

The member below is currently receiving services and has consented to share the following information between his/her PCP and BH provider.

In an effort to increase communication and promote care coordination between providers, we ask that you review and/or complete the following health information.

Member name: _____ DOB: _____ Member ID#: _____

A signed copy of the release of information (ROI) must be attached to this form. Indicate date of expiration of ROI: _____

Section A: ***(completed by BH Provider)***

1. The patient is being treated for the following behavioral health problem(s) and/or diagnoses: (list all)

_____ _____

_____ _____

2. The patient is taking the following medication(s): (list all prescribed and OTC medications, with dosage and frequency as applicable)

_____ _____

_____ _____

_____ _____

Prescriber: _____

3. The patient has the following substance abuse problem(s) (if applicable):

_____

_____

_____

4. Please describe any special concerns:

_____

_____

_____

_____

Behavioral Health Clinician: _____

Behavioral Health Clinician Signature: _____

Provider Name/Site Name: Elizabethtown Partners In Counseling

Address: 204 N. Main St.
Elizabethtown, KY 42701

Phone: 270-360-1222

Fax: 270-360-0333

Date this form completed:

Section B: ***(completed by Primary Care Provider)***

1. The patient is being treated for the following medical problem(s) and/or diagnoses: (list all)

_____ _____

_____ _____

2. The patient is taking the following medication(s): (list all prescribed and OTC medications, with dosage and frequency as applicable)

_____ _____

_____ _____

_____ _____

3. The patient has the following BH (MH/SA) problem(s) (if applicable):

_____

_____

_____

4. Please describe any special concerns (i.e., include abnormal lab results):

_____

_____

_____

_____

Primary Care Provider: _____

Primary Care Provider Signature: _____

Provider Name/Site Name: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

Date this form completed:

ELIZABETHTOWN PARTNERS IN COUNSELING
204 N. Main Street, Elizabethtown, Kentucky 42701
270-360-1222

OFFICE POLICIES AND PROCEDURES

1. **ABOUT YOUR APPOINTMENT:** Please arrive promptly. If children will be coming with you, another adult must accompany you to ensure the children are properly supervised in the waiting area during your session. A child under the age of eight will not be permitted to remain in the waiting room unattended.

2. **TURN OFF ALL CELL PHONES, PAGERS, ETC. WHILE IN THE BUILDING.**

3. Initial sessions are $175.00, run 45-60 minutes, and will begin on the hour. Follow-up visits continue to be scheduled on the hour, at a rate of $125 per session. Longer or shorter sessions may be scheduled depending upon individual needs, but usually insurance companies do not allow for more than one hour-long session per week. If you do not carry insurance, or your insurance does not cover Behavioral Health Services, please ask about our self-pay rates.

4. Scheduling presents a unique challenge in our practice because once a given time is blocked for a client: it usually cannot be filled again on a short notice if it is cancelled. If you must cancel your appointment, we urge you to give at least a 48 hour notice and we will try to reschedule you as son as possible. **APPOINTMENTS THAT ARE SCHEDULED AND SIMPLY NOT KEPT WILL BE SUBJECT TO A NO SHOW FEE OF $50 THAT IS NOT BILLABLE TO YOUR INSURANCE. IN ADDITION THE SAME FEE ALSO APPLIES TO LATE CANCELLATIONS (LESS THAT 24 HOUR NOTICE).** Patients that have missed two or more scheduled appointments will not be rescheduled without prior approval from the therapist. **Our office will attempt to contact all patients the day prior to their appointments, but it is ultimately the patient's responsibility to keep track of his/her appointments.**

5. Occasionally, telephone contact is necessary between sessions when issues arise or a crisis develops. We encourage you to keep telephone contact brief, if possible, and try to address the issue during your regular therapy session. Telephone calls that are 10-15 minutes or more will be billed at a rate of $30 per quarter hour (also NOT billable or reimbursable from your insurance).

6. **PRESCRIPTION REFILLS:** Refills on medications must be requested at least FOUR DAYS IN ADVANCE. Same day prescription refills may no longer be available.

7. **READING MATERIAL:** Please return all borrowed books and reference materials in a timely manner, so that others may benefit from our resources. You will be responsible for the purchase/replacement price of books not returned.

8. **FINANCIAL RESPONSIBILITIES:** All charges incurred **ARE YOUR RESPONSIBILITY,** regardless of insurance coverage. We must emphasize that as your mental health care provider, our relationship is with you, **NOT** your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. We will make every effort to collect from your insurance company. However if the payment is **NOT** received from them within 60 days from the date of service, YOU will be responsible for resolving the issue with your insurance company or paying the balance in full. **CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.** You will not be permitted to accrue large balances on your account. If your check is returned for insufficient funds, you are responsible for all bank fees, as well as cash payment for the returned check. Any future payments must be made in cash, as we will not accept a check. Delinquent accounts will be sent to our collection agency. If your account is sent to collections, we will not be able to continue to provide services (including medication prescriptions and refills) to you until the account has been paid in full.

NOTICE OF PRIVACY PRACTICES

Client Copy

ELIZABETHTOWN PARTNERS IN COUNSELING
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

This Notice is effective as of APRIL *14, 2003.*

Federal Law (the Health Insurance Portability and Accountability Act (HIPAA) requires that health care providers inform patients of their rights regarding how the provider 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. This Privacy Notice describes our privacy practices that relate to your protected health information. It also describes your rights to access and control your protected health information. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health condition.

Contact Person:
Elizabethtown Partners in Counseling's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. If you feel that your privacy rights have been violated by this agency; you may submit a complaint to our Privacy Officer by sending it to:

Elizabethtown Partners in Counseling, Inc.
204 North Main Street
Elizabethtown, Kentucky 42701
ATTN: Privacy Officer

Or the Privacy Officer can be contacted at: (270) 360-1222.

We are required by law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. You have the right to obtain another paper copy of this Notice upon request even if you have already received a copy.

We are required to abide by the terms of the Notice of Privacy Practices that is most current. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be posted in the waiting room (IF APPLICABLE: and on our web site). You may request a copy of the revised Notice at any time.

Uses and Disclosures of Protected Health Information

Elizabethtown Partners in Counseling may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless we have obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

TREATMENT: We may use and disclose your protected health information to provide, coordinate, or manage your healthcare and other related services. This includes coordination or management of your healthcare with other providers and agency staff involved in your care or a third party for t treatment purposes (i.e. we may disclose your protected health information to a laboratory to order tests or to a pharmacy to fill a prescription). We may also disclose protected health information to physicians who may be treating you or consulting with us with respect to your care.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for the services we provide. This may include certain communications to your health insurance company to get approval for the service we have scheduled. For example, we may need to disclose information to your health insurance company to get prior approval for the services. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered by your health plan. In order to get payment for services we provide to you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose information to another provider involved in your care for the provider's payment activities.

HEALTHCARE OPERATIONS: We may use or disclose your protected health information, as necessary for our own operations to facilitate the function of Elizabethtown Partners in Counseling, and to provide quality care to all patients. Healthcare operations include such activities as: quality assessment and improvement activities, employee review activities, training, healthcare practitioners under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services, and maintaining compliance programs, business management and general administrative activities. We may share your protected health information with third party business associates that perform various activities such as billing, transcription 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.

We may use or disclose your protected health information to contact you, a family member or friend involved in your health care or as authorized by you as a reminder that you have an appointment for treatment at our agency. We may also leave a message on your answering machine or voicemail system unless you have requested otherwise.

Uses and Disclosures of Protected Health Information Based on 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 such an authorization, at any time, in writing, except to the extent that your provider or your provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization. An authorization is written permission above and beyond the general consent that permits only specific disclosures. We will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy notes are notes that have been made about specific conversations during a

private, group, joint, or family counseling session, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than protected health information.

You may revoke all such authorizations, of protected health information or psychotherapy notes, at any time, provided each revocation is in writing. You may no9t revoke at authorization to the extent that: 1) we have relied on that authorization; or 2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides t he insurer the right to contest the claim under the policy.

Uses and Disclosures That May Be Made Without Your 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 yc 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 provider 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.

Required by law: We may use or disclose your protected health information to the extent that the use of 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.

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 protec health information that directly relates to that person 's involvement in your healthcare. 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 risk of harm. 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 healthcare.

Specific circumstances requiring disclosure: 1) Child Abuse or Neglect: We may disclose your protected health information to public officials who are authorized by law receive reports of abuse, neglect or violence. If we have reasonable cause to believe that a dependent child is/has been neglected or abused, we must report this belief to the appropriate authorities, which may include the Kentucky Cabinet for Families and Children, Department for Community Based Services or its designated representative; the commonwealth's attorney or the county attorney; or local law enforcement agencies or Kentucky state Police. Dependent child means any child, other than an abused or neglected child, who is under improper care, custody, control, or guardianship that is not due to an intenti9onal act of the parent, guardian, or person exercising custodial control or supervision of the child. 2) Adult and Domestic Abuse: We may disclose your protected health information if we have reasonable cause to beli3eve that an adult l suffered abuse, neglect or exploitation. This must be reported to the Kentucky Cabinet for Families and Children/Department for Community Based Services. 3) Health Oversight Activities: Our professional board/licensing entity may subpoena records that are relevant to its disciplinary proceedings and investigations. 4) Judicial and Administrative Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request or other lawful process. you are involved in a court proceeding and a request is made for information about your diagnosis and treatment records, such information is JPRIVILEDED UNDER STATI LAW, and will NOT be released without your written authorization or your personal or legally appointed representative, or a court order. This privilege does NOT apply whe you are being evaluated for a third party or where the evaluation is Court-ordered. You will be informed in advance if this is the case. .5) Serious Threat to Health or Safety: we have a reasonable belief that an actual threat of physical violence against a clearly identified or reasonably identifiable victim or an actual t threat of some specific violent act, your protected health information will be disclosed to the victim and law enforcement authorities. If we have reasonable cause to believe that you are in danger of life threatening harm, your protected health information will be disclosed to your nearest designated relative, caregiver, hospital, and/or current healthcare provider. 6) Workers' Compensation:

Your Rights Regarding Your Protected Health Information

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.

Right to inspect and copy your protected health information: This means you may inspect and obtain a copy of protected health information about you t hat is contained in 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 you provider 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 tl 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 Officer you have questions about access to your medical record.

Right to request amendments to your protected health information: This means you may request an amendment of protected health information about you in a designated recor5d set for as long as we maintain t his 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. In addition, we may deny your request if you ask us to amend information that: 1) was not created by this agency, unless the person or entity that created the information is no longer available make the amendment; 2) is not part of the health information kept by our agency; 3) is not part of the information which you would be permitted to inspect and copy; or 4) accurate and complete.

Requests for amendment must be submitted in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the r requested amendments.

Right to request a restriction on uses and disclosures of your protected health information: You may request us not to use or disclose certain parts of your health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friend who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply. For example, you could ask that we not use or disclose information about a service you had, or that certain people are not told of certain information. We are not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If we agree to the requested restriction, we may not use or disclose your health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstance we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

Right to request to receive confidential communications from us by alternative means or at an alternative location: You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternate address or other method of contact. We will not require you to provide an explanation for your request. An example might be that you may not want a family member to know that you are receiving services. On your request, we will send your bills to another address. Requests must be made in writing to our Privacy Officer.

Right to receive an accounting: You have the right to request an accounting of certain disclosures of your health information made by us. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. This request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent account requests may be subject to a reasonable cost based fee.

Right to obtain a paper copy of this notice: Upon request, we will provide a separate paper copy of this notice, even if you have already received a copy. We will also ask that you sign a copy of the receipt of notice of privacy practices, which we will file in your record. You will also be asked so sign the form when revisions are made to the original privacy notice.

Our Responsibilities: We are required by law to maintain the privacy of your health information and to provide you with this privacy notice of our duties and privacy practices. We are required to: 1) keep your health information private and only disclose it when required to do so by law; 2) explain our legal duties and privacy practices in connection with your health records; 3) obey the rules found in this notice; 4) inform you when we are unable to agree to a requested restriction that you have given us; 5) accommodate your reasonable request for an alternative means of delivery or destination when sending your health information.

COMPLAINTS: You have the right to express complaints to us and to the Secretary of Health and Human Services, if you believe that your privacy rights have been violated. You may complain to us by contacting our Privacy Officer verbally or in writing, using the contact information provided on the front of this Privacy Notice. We encourage you to express any concerns that you may have regarding the privacy of your information.