The Tree House

CENTER for GROWTH and LEARNING

REGISTRATION AND RELEASE FORMS - GROUP THERAPY

Participant's Name: _____

Participant's Date of Birth: _____

Gender: Male or Female (Circle One)

Parents or Guardian Name: _____

_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Mom's Cell: _____ Dad's Cell: _____

Email: _____

School and Grade Attending:

_____

Emergency Contact: _____ Relationship: _____

Emergency Phone : _____

Email:

_____

Please share your referral source: (Circle One): Long Grove Psych Associates - Familiar with an instructor - Media Social Site - Search Engine - Word of Mouth - Radio Advertisement - Other:

RELEASES

I. the undersigned do hereby grant or deny permission ask indicated below to use the image of my child. Such use includes the display, distribution, publication, transmission, or otherwise use of photographs, images, and/or video taken of my child for use in materials that include, but may not be limited to education purposes, printed materials such as brochures and newsletters, videos, and digital image such as those on the Web site.

Please Respond*
__I give permission for my child's image to be used in print, video, and digital media for advertising and education purposes
__I do not give permission for my child's image to be used in print, video and digital media for advertising and education purposes.

Signature_____Date:_____

Please indicate any medical information, diagnoses or food allergies or any other information that staff should be aware of:

_____

_____

_____

RELEASE AND HOLD HARMLESS WAIVER

Please review the Release and Waiver, Registration and Financial policies and check the box and print your name below to acknowledge that you have read and agree with the policies. MY signature constitutes an acceptance of all the Tree House policies as listed.

By their very nature, some of our programs involve physical exertion, emotional stress, and/or use of equipment which represents a certain risk. It is recommended that you check with your physician prior to participating in our exercise activities. The Tree House Growth and Learning Center does not provide insurance protection for participants in our activities. Please read the following information carefully and be aware that in registering yourself or your minor child/ ward for participation in the above program(s), you will be waiving and releasing all claims for injuries you and your child/ward might sustain arising out of our programs. I give my child permission to participate in this program, therapy or activity and hereby waive, release and forever discharge any and all claims against the Tree House Center for Growth and Learning, Long Grove Psychological Associates, or its commissioners, employees, practitioners, independent contractors or volunteers for damages, emotional stress and/or injuries to the registrant, which may arise from participation in the Tree House Center for Growth and Learning programs. INITIALS:_____

EMERGENCY TREATMENT: A minor may not be treated, even in an emergency, except when, in the opinion of the attending physician, a life is in the balance. Written consent is required for all treatment given in any hospital emergency room/center. Consent of a parent or legal guardian is necessary for unmarried minors, under age 18, except in cases of extreme emergencies. INITIALS: _____

TO WHOM IT MAY CONCERN: As a parent and/or legal guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the above minor in the event of a medical emergency which, in the opinion of the

attending physician may endanger his/her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me. The release form is completed and signed of my own free will with the purpose of authorizing medical treatment under emergency circumstances in my absence. INITIALS:_____

Please list specific medical allergies, medicines, or other conditions:

Release and Hold Harmless Statement on registration form must be signed prior to the start of therapy or class and will be valid for one year. PARTICIPATION WILL BE DENIED if the signature of adult participant or parent/ guardian and date are not on this waiver.

My signature, or my guardian's signature below, if I'm under 18, indicates I HAVE READ AND FULLY UNDERSTAND THE REFUND POLICY AND WAIVER and understand it is required to take part in The Tree House Center for Growth and Learning programs.

Signature_____Date:_____

FINANCIAL POLICY

Welcome to the Tree House Center for Growth and Learning! We will be pleased to discuss our professional fees with you at any time, however, your clear understanding of our Financial Policy is important at the outset of our professional relationship, in order to minimize any later misunderstandings. Please ask if you have any questions about our fees or policy. We accept cash, checks, FASA cards, and Visa/MasterCard/Discover/AmericanExpress.

Consistency of Treatment:

We are committed to providing you and your child(ren) with the best possible care. Although we intentionally make all of our groups fun and meaningful for the children attending, our **groups are therapeutic in nature and should be considered as therapy for your child**. In order for your child to make measurable gains with respect to his or her therapy goals, we strongly encourage very consistent attendance during the session. Because we individualize goals for your child that may be difficult for him or her to work on, your child may experience uncomfortable feelings from time to time during the session. However, therapeutic groups such as ours have been researched and shown to have many benefits for children. We have also collected data within our own groups and have seen significant growth of our participants in areas such as self-esteem and confidence from session to session. (If you would like more information about this, please contact us). With consistency and dedication, therapy often leads to among many positives, better relationships, better feelings about oneself, solutions to specific problems, and significant reductions in feelings of stress and anxiety.

Initial:_____

In-Network Provider:
We are in network providers for Blue Cross Blue Shield and Aetna insurance companies. We participate directly with

these health plans. We will submit claims to your carrier for reimbursement. Co-pays and Deductibles must be paid at the time of service. For your convenience we will ask for you to have a credit card put on file to be charged at the time of service. Otherwise, we can accept checks or cash on a weekly basis.

Please request your weekly amount that will be due. We will estimate this amount although it may change once your insurance is processed. Please contact us for more information regarding your specific insurance plan.

Initial:_____

Out-of-Network Insurance:
(All insurance plans except Blue Cross Blue Shield and Aetna)
For insurance plans that are not BCBS or Cigna, we are currently an out-of-network provider, which means that we do not participate directly with your health plan. Full payment for the session must be submitted at the time of registration unless we have come to a private agreement. Although we will pro-rate fees for known absences prior to the session, no refunds are available after classes begin for missed classes for any reason. Most Traditional, PPO, and POS plans have optional "out-of-network" benefits that provide coverage for psychological sessions. Unless you have an HMO, you will likely be covered for a significant portion of our services. Receipts will be available after attendance for your submission to your insurance company. Please contact your insurance company for a more detailed explanation of your benefits.

Initial_____

Absences:

In order for your child to make measurable gains with respect to his or her therapy goals, we strongly encourage consistency of attendance within the session. However, given the length of some of our sessions, illness and other family matters, we understand that this is not always possible. **Prior to the session beginning, please let us know in writing any known dates your child will not be able to attend**. You will not be charged for these absences.

Initial:_____

Unexcused Absences and Drop Outs:

We strictly limit the enrollment of our groups for your child's benefit, therefore, we are financially dependent on his or her attendance during any given session. There will be absolutely no refunds for groups for any reason after the session begins. Along with the above mentioned known dates of absences, your child will also be afforded one excused absence per session for illness to be used at your discretion. After this is used, we will require a doctor's note to excuse any other absences. We cannot bill your insurance if your child is not in attendance in group therapy. **If your child's absence from group is considered unexcused, you will be charged the full cost of the specific missed group. Once the session has started, we will consider your registration as a commitment to the session you have registered for. If you choose to pull your child from the group prior to the session ending, unless you have direct permission from the Clinical Director, you will be charged the full cash amount of the remaining days in the session.** I authorize the Tree House CGL to charge unexcused absences and/or the full cash session amount if I pull my child from group without permission.

Initial:_____

Billing:

Prior to the session, we will request credit card information be kept on file. We are unable to treat your child in therapy without a valid credit card on file. We will charge your credit card at the time of service. After 45 days of any non-payment we will attempt to charge the overdue fees to your credit card that we have on file. If we are unsuccessful we will use a collecting agency to recover non-paid fees, and this will revoke your right to privacy with respect to disclosure in regards to your name, your child's name, address, and services rendered. Your credit card will not be charged for any other reason without your permission.

However, we are here to help. Please let us know if you are having difficulty paying your account. We may be able to help you by setting up a payment plan based on your financial hardship, call (847) 975-5598 for assistance.

Initial:_____

I have read, initialed and have agreed to the financial policies disclosed above.

My Child's Name:_____

My Name:_____

Signature:_____

Date:_____

Credit Card Authorization Form

All information will remain confidential.

Registration Information:

Name of Child: _____

Group: _____ Dates: _____Fee $: _____

Credit Card Payment Information:

Cardholder Name: _____

Billing Address: _____

_____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: _____

CVV Code (3 digit # on back for Visa, MC, Discover OR 4 digit #on front for Amex) : _____

Amount to Charge: $ _____ (USD)

I authorize THE TREE HOUSE CENTER FOR GROWTH AND LEARNING to charge the agreed amount listed above to my credit card provided herein. I authorize THE TREE HOUSE CENTER FOR GROWTH AND LEARNING to charge the amount of an unexcused absence and/or in the situation of an unexcused drop-out the full amount of the remaining groups in the session, I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Print Name, Sign and Date Below:

Signed: _____

Date: _____

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____

ID # ON CARD: _____

GROUP: _____

CUSTOMER SERVICE OR MENTAL HEALTH NUMBER ON CARD: _____

NAME OF PRIMARY INSURANCE HOLDER: _____

PRIMARY HOLDER DATE OF BIRTH: _____/_____/_____
NAME OF PARTICIPANT: _____
PARTICIPANT DATE OF BIRTH: _____/_____/_____
RELATIONSHIP TO PARTICIPANT: _____

ADDRESS OF PRIMARY INSURANCE HOLDER: _____

_____

ADDRESS OF PARTICIPANT (IF DIFFERENT): _____

_____

HOME PHONE:_____

CELL PHONE: _____

EMAIL ADDRESS: _____
EMPLOYER: _____

Who is financially responsible for the account? _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I_____, authorize the Tree House Center for Growth and Learning to release information as to my or my dependent's diagnosis and treatment to my insurance company for the sole purpose of validating my claim. I also assign my insurance benefits to my provider and I authorize payment to be made directly to the office by my insurance company.

Signature: _____

INFORMED CONSENT

I consent to allow The Tree House CGL to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

Information related to the scheduling of meetings or other appointments Information related to billing and payment
Information related to treatment or therapeutic goals
All other information needed for therapeutic treatment

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Your signature below indicates that you have read our Informed Consent agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPPA notice form described above.

Printed name of parent or guardian:_____

Signature of parent or guardian:_____

Client/Guardian Date Child (ages12-18):_____

Date:_____

RELEASE OF INFORMATION

Tree House Center for Growth and Learning
4160 Route 83
Suite 211
Long Grove, IL 60047
847-975-5598

This form when completed and signed by you, authorizes us to release protected information from your clinical record to the person you designate.

I authorize Dr. Christine Decker, PsyD, Clinical Psychologist and/or the administrative and clinical staff to release information regarding my child's clinical and therapeutical goals and any other information necessary to provide solidified treatment.

This information should only be released to and between Christine Decker, PsyD and all Tree House staff including but not limited to: Rebecca Canastra. MA, Julie Ludwick, LCPC, Margaret Pragalz, Jennifer Wagner, LCSW, Ameera Khan, LCP, Caryn Goldberg, LCPC, Genny Chesney, LSW, and Jillian Cohen.

I am requesting Dr. Decker to release this information for the following reasons: solidify treatment goals and interventions and at the request of the individual

This authorization shall remain in effect until (fill in expiration date. If no calendar date is stated, information may be released only on the day the authorization form is received by the psychologist)
A year from the date this document was signed.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Dr. Decker generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand I have the right to inspect the disclosed mental health information at any time.

I understand that Illinois law prohibits redisclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such redisclosure.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Signature of child ages 12-17 Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

_____ _____
Witness Date

ART RELEASE

I __Do __Do Not give permission to display my/my child's artwork at The Tree House Center for Growth and Learning.

I __Do __Do Not give permission for my/my child's name to be displayed with their artwork at The Tree House Center for Growth and Learning.

I __Do __Do Not give permission for photographs of my/my child's artwork to be publicized through The Tree House Center for Growth and Learning and/or educational materials or presentations Julie Ludwick, LCPC, ATR or Ashley Samson, LCPC, ATR implements.

I __Do __Do Not give permission for videotape of my/my child's artwork to be publicized through The Tree House Center for Growth and Learning and/or educational materials or presentations Julie Ludwick, LCPC, ATR or Ashley Samson, LCPC, ATR implements.

I __Do __Do Not give permission for photographs of me/my child to be publicized through The Tree House Center for Growth and Learning and/or educational materials or presentations Julie Ludwick, LCPC, ATR or Ashley Samson, LCPC, ATR implements.

I __Do __Do Not give permission for videotape of me/my child's to be publicized through The Tree House Center for Growth and Learning and/or educational materials or presentations Julie Ludwick, LCPC, ATR or Ashley Samson, LCPC, ATR implements.

Participant name (printed): X:_____

Signature of participant: X: _____

Signature of parent of guardian if participant is under 18 years of age:

X: _____

Date: _____

This waiver is valid for the artwork displayed at The Tree House Center for Growth and Learning and all artwork created during art therapy sessions that Julie Ludwick, LCPC, ATR or another art therapist, LCPC, ATR implement and facilitate at The Tree House Center for Growth and Learning, Long Grove, IL

PLEASE DETACH THE REST OF THE PAGES FOR YOUR RECORDS

The Tree House Center for Growth and Learning
4160 Route 83
Suite 211
Long Grove, IL 60047
(847) 975-5598

PSYCHOLOGIST/THERAPIST-CLIENT SERVICES AGREEMENT

Welcome to the The Tree House Center for Growth and Learning. This document contains important information about our professional services and business policies. It also contains a summary of information about the Health Insurance Portability and Accountability Act (HIPPA). This is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPPA requires that we provide you with a Notice of Privacy Practices and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPPA and its application to your personal health information in greater detail.

The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next meeting. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke the Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you or your child is experiencing. There are many different methods we may use to deal with the problems you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you may be asked to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of this evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with us. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have ay questions

about our work, we should discuss them as soon as they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

We typically schedule a group session for one day per week. However, depending upon the circumstances, some sessions may vary in length and frequency. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for cancelled session.**

PROFESSIONAL FEES

Our hourly therapy rate is 200.00. The first two sessions are considered as assessments and our hourly rate for these sessions is $250.00. All phone conversations or written correspondence exceeding 10 minutes will be billed at our hourly therapy rate.
Payment of your bill is expected to be met in a timely fashion. After 45 days of non-payment The Tree House Center for Growth and Learning will use a collecting agency to recover non-paid fees, and this will revoke your right to privacy with respect to disclosure in regards to your name, address, and services rendered.

CONTACTING US

You can contact us at 847.975.5598 We will return phone calls within 24-48 hours Monday-Friday.

LIMITS ON CONFIDENTIALITY

- The law protects the privacy of all communications between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPPA and/or Illinois law. However, in the following situations, no authorization is required.

- ! I may occasionally find it helpful to consult with other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- ! Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

- ! If you are involved in court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot disclose any information without a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- ! If a government agency is requesting the information for health oversight activities, I may be required to provide them.

- ! If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- ! If you file a worker's compensation claim, and I am rendering treatment or services in accordance with the provisions of Illinois Workers' Compensation law, I must, upon appropriate request, provide a copy of your record to your employer or his/her appropriate designee.
  There are some situations in which I am legally obligated to take actions, which I believe are necessary to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.
  ! If I have reasonable cause to believe a child under 18 known to me in my professional capacity may be an abused child or a neglected child, the law requires that I file a report with the local office of the Department of Children and Family Services. Once such a report is filed, I may be required to provide additional information.

- ! If I have reason to believe that an adult over the age of 60 living in a domestic situation has been abused or neglected in the preceding 12 months, the law requires that I file a report with the agency designated to receive such reports by the Department of Aging. Once such a report is filed, I may be required to provide additional information.

- ! If you have made a specific threat or violence against another, I may be required to disclose information in order to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking your hospitalization.

- ! If I believe that you present a clear, imminent risk of serious physical or mental injury or death to yourself, I may be required to disclose information in order to take protective actions. These actions may include seeking your hospitalization or contacting family members or others who can assist in protecting you.
  If such a situation arises, I will make every effort to fully discuss it with you before taking an action and I will limit my disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future.

- **PROFESSIONAL RECORDS**
  The laws and standards of my profession require that I keep PHI about you in your Clinical Record.
  You may examine and/or receive a copy of your Clinical Record, if you request it in writing. I will charge $2.00 per page.
  Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress toward these goals, your medical and social record, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including your insurance carrier.

PATIENT RIGHTS
HIPPA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discus any of these rights with you.

MINORS AND PARENTS
Clients under 12 years of age and their parents should be aware that the law allows parents to examine their child's treatment records. Parents of children between 12 and 18 cannot examine their child's record unless the child consents and unless I find that there are no compelling reasons for denying access. If I feel that the child is in danger or is a danger to someone else, I will notify the parents of my concern. **We will not testify in court regarding therapy in divorce/child custody proceedings.**

COMMUNICATION BY EMAIL, TEXT MESSAGE, AND OTHER NON-SECURE MEANS
It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with staff or therapists at the Tree House Center for Growth and Learning (The Tree House CGL), there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your life that you don't want accessing these communications. Please talk with staff at the Tree House CGL about ways to keep your communications safe and confidential.

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with The Tree House CGL
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

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

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

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

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

- ! ***"PHI"*** refers to information in your health record that could identify you.
- ! ***"Treatment, Payment, and Health Care Operations"***
  -*Treatment* is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  -*Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility coverage.
  -*Heath Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, and case management and care coordination.
  ! ***"Use"*** applies only to activities within our office and practice such as sharing, employing, utilizing, examining, and analyzing information that identifies you.
  ! ***"Disclosure"*** applies to activities outside of our office and practice such as releasing, transferring, or providing access to information about you to other parties.
  ! ***"Authorization"*** is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization
We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when we are asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain authorization before releasing our Psychotherapy Notes. "*Psychotherapy Notes*" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your record. These notes are given a greater protection than PHI.
You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

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

- ! ***Child Abuse*** – If we have reasonable cause to believe a child known to us in our professional capacity may be an abused child or a neglected child, we must report this belief to the appropriate authorities.
- ! ***Adult and Domestic Abuse***- If we have reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, we must report this belief to the appropriate authorities.

- ! ***Health and Oversight***- We may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions.

- ! ***Judicial and Administrative Proceedings*** – If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment, and the records thereof, such information is privileged under state law, and we must not release such information without a court order. We can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.

- ! ***Serious Threat to Health or Safety*** – If you communicate to us a specific threat of imminent harm against another individual or if we believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, we may make disclosures that we believe are necessary to protect that individual from harm. If we believe that you present an imminent, serious risk of physical or mental injury or death to yourself, we may make disclosures we consider necessary to protect you from harm.

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

Patient's Rights and Psychologist's and Therapist's Duties

Patient's Rights:

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

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

- ! ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record and Psychotherapy Notes. On your request, we will discuss with you the details of the request for access process.

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

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

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

Psychologist's and Therapist's Duties:

- ! We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

- ! We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are not required to abide by the terms currently in effect.

- ! If we revise my policies and procedures, we will make written notices available to you.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

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

This notice will go into effect on April 15, 2003.

We reserve the right to change the terms of this notice and make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by giving you a copy of revisions.

All files are kept a minimum of 7 years. After this time, all information except a data sheet is shredded. If you are under age 18, the 7-year period does not start until your 18th birthday.