Patient Information

Date:_____

Name:_____ Cell Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____

May we contact you by e-mail? Yes No **May we text you with appointment reminders? Yes No**

Age:_____ Birth Date:_____ Sex: M F Race:_____ Marital Status: M S W D

Occupation:_____ Employer:_____

Spouse:_____ Occupation:_____ Employer:_____

Names and Ages of Children:_____

_____

Emergency Contact:_____ Phone:_____

How were you referred to our office?_____

Family Medical Doctor (first and last name): _____

When healthcare professionals work together it benefits you. ***May we have your permission to update your medical doctor regarding your care at this office?*** **Yes No**

Please indicate the conditions that apply to you. P – Past C - Current

__ Anxiety
__ Anger
__ Abandonment
__ Suicidal thoughts
__ Other: _____

__ Depression
__ Post Traumatic Stress Disorder
__ Alcoholism
__ Suicide Attempts
__ Other: _____

__ Eating Disorder
__ Self-Harm
__ Drug Addiction

Have you been treated for any health condition by a physician in the last year? **Yes No**

If yes, describe: _____

Medications or drugs you are taking including medical marijuana: (List name and dosage)

_____

_____

Have you received mental health or substance abuse services either inpatient our outpatient previously? **Yes No**

If yes, describe including dates:_____

_____

Do you drink alcoholic beverages?_____ If so, how much per week?_____
Do you use recreational drugs?_____ If so, how much per week?_____
Do you exercise?_____ If yes, what is the frequency and type of exercise?_____
Do you sleep well at night? _____ If no, why not? _____
Have you experienced any changes in appetite? ____ If so, describe:_____
How would you describe your current support network (friends, relatives, etc.)? _____

_____

Patient Name: _____ Date: _____

FAMILY HISTORY:

Parents:

Father: Living? **Yes** **No** City/State of Residence: _____
If deceased, cause of death and age at death: _____

Mother: Living? **Yes** **No** City/State of Residence: _____
If deceased, cause of death and age at death:_____

FAMILY DISEASES (if applicable indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

__ Anxiety
__ Anger
__ Abandonment
__ Suicidal thoughts
__ Other:_____

__ Depression
__ Post Traumatic Stress Disorder
__ Alcoholism
__ Suicide Attempts
__ Other: _____

__Eating Disorder
__ Self-Harm
__ Drug Addiction

Describe any family problems which occurred while growing up relating to:

Alcohol/Drug Use: _____

Sexual/Physical/Emotional Abuse:_____
_____

AUTHORIZATION AND RELEASE: I authorize Options Counseling Service, Inc. to contact me via email and/or text messaging to remind of an appointment, send an invoice, obtain feedback about my experience with staff, and to provide general health information.

The patient/client understands and agrees to allow this healthcare office to use his/her Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE provided to you. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Name _____ **Date** _____

1. What are your major concerns? _____

_____

_____

_____

2. When was the first time you noticed this problem? _____

Do you know what caused it to originally occur? **Yes** **No** If yes, please describe: _____

_____

Has it recently become: ___ Worse ___ Same ___ Better

3. How frequent is the condition? ___ Constant ___ Intermittent

What causes the problem to come on/get worse?

_____

_____

4. Is there anything you can do to bring relief? **Yes** **No** If yes, describe:

_____

If no, what have you tried to do that has not helped? _____

_____

5. Please check any of the following that describe how you have been feeling lately:

___ sad ___ anxious ___ depressed ___ frightened ___ guilty

___angry ___ ashamed ___ aggressive ___ worthless ___ jealous

___ hopeless ___ helpless ___ extreme ups/downs

___ Other:_____

Please place an "X" on the line below to indicate current level of distress.

NO SYMPTOMS/DISTRESS — EXTREME SYMPTOMS/DISTRESS

6. What would you like to accomplish from therapy/counseling? _____

_____

_____

_____

Options Counseling Service, Inc.

SUBSTANCE/LEGAL HISTORY

SUBSTANCE USE HISTORY:

	Age Onset	Amt./Freq.	Route of Adm.	Last Used
Alcohol				
Marijuana				
Methamp.				
Cocaine				
Hallucinogens				
Inhalants				
Others(List)				

Which drug(s) is a major problem?_____

LEGAL HISTORY:

How many times in your life have you been arrested and charged with the following:

shoplifting/vandalism _____ parole/probation violations _____
drug charges _____ forgery _____
weapons offense _____ burglary, larceny, B & E _____
robbery_____ assault _____
arson_____ rape _____
homicide, manslaughter_____ prostitution _____
contempt of court _____ PI, DUI, DWI, DUID_____
major driving violation_____ other _____

How many of these charges resulted in convictions?_____

How many months were you incarcerated in your life? Mos._____
What was it for? _____

LEGAL CHARGES/OUTCOMES:

Date	Charges	Outcome

Have you ever received Substance Abuse Treatment either inpatient or outpatient? **Yes** **No**
If yes, please list dates and locations: _____
_____

Are you now or have you ever participated in a 12 step program? **Yes** **No**

FAMILY HISTORY:

Have any of your relatives had what you would call a significant drinking or drug use problem—one that did or should have led to treatment?

DIRECTIONS: Y(yes) N(no) U (unknown/uncertain)

	Mother's side		Father's side		Siblings	
	Alcohol	Drugs	Alcohol	Drugs	Alcohol	Drugs
G.mother	_____	_____	G.mother_____	_____	Bro._____	_____
G.father	_____	_____	G.father _____	_____	Bro._____	_____
Mother	_____	_____	**Father** _____	_____	Bro._____	_____
Aunts	_____	_____	Aunts _____	_____	Sister_____	_____
Uncles	_____	_____	Uncles _____	_____	Sister_____	_____
Other	_____	_____	Other _____	_____	Sister_____	_____

CLIENT VIEW OF SELF/SITUATION:

Personal Strengths_____

Personal Weaknesses_____

Personal Goals:

Short-term:_____

Long-term:_____

Expectations/goals for counseling: _____

_____

_____

_____ _____

CLIENT SIGNATURE DATE

INSURANCE INFORMATION

CLIENT NAME:_____ **FOR OFFICE USE ONLY:**
DOB:_____ **Dx:** _____

Are you covered by Sooner Care? Yes No

Sooner Care Member ID:_____

Are you covered by insurance? Yes No

Insurance Company:_____

Subscriber's Name:_____
Last First Middle

Subscriber's DOB: ____/____/_____

Subscriber's Address: _____
City State Zip

Your relationship to Subscriber: ___Self ___Parent ___Child
___Spouse ___Step-Parent ___Other _____

Are you covered by secondary insurance? Yes No

Insurance Company:_____

Subscriber's Name:_____
Last First Middle

Subscriber's DOB: ____/____/_____

Subscriber's Address: _____
City State Zip

Your relationship to Subscriber: ___Self ___Parent ___Child
___Spouse ___Step-Parent ___Other _____

Is this an Employee Assistance Program (EAP) Visit? Yes No

Name of EAP Provider:_____

Authorization #:_____

Number of sessions authorized:_____

Options Counseling Service, Inc.

We ask you to place a credit card on file for future billing purposes. (**PLEASE SEE FINANCIAL POLICY BELOW**.)

By providing your credit/debit card information and signing below, you are stating you understand your information will be saved to file for future transactions on your account and are authorizing Options Counseling Service, Inc. to charge your credit/debit card for:

CO-PAY FOR EACH APPOINTMENT * ANY BALANCE THAT IS 90 DAYS PAST DUE * MISSED APPOINTMENT FEE

CREDIT CARD: ☐ AMEX ☐ VISA ☐ MC ☐ DISCOVER
CARDHOLDER'S NAME _____
EMAIL ADDRESS_____
CARD # _____ EXP. DATE _____
THREE DIGIT CID NUMBER _____ BILLING ZIP CODE _____

FINANCIAL POLICY:

Counseling Session Fees:

Intake session:	$200.00	Cash Discount Fee $110.00
60 minute session:	$175.00	Cash Discount Fee $110.00
45 minute session:	$150.00	Cash Discount Fee $95.00
30 minute session	$100.00	Cash Discount Fee $80.00

Assessments/Reports/Court Appearances:

Mental Health Assessment: $350.00
Written Report: $50.00
Court Appearance: $110.00 per hour
Testing/Assessment: Fee is based on type of evaluation required.

Missed Appointments:

A $50.00 fee will be charged for no call/no show appointments and for appointments cancelled with less than 12 hours' notice. The charge will be applied to your credit card on file within 24 hours of the missed appointment. If payment is unable to be collected, future appointments will not be made.

CO-PAYS AND SELF-PAY FEES ARE DUE AT THE TIME OF YOUR APPOINTMENT.

Insurance Authorization: I authorize payment of insurance benefits directly to the therapist or therapist's office. I authorize the therapist to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of therapy and counseling care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable.

I have read and agree to the above terms and authorize Options to file insurance on my behalf and to charge the above credit card as set out above.

_____ _____
SIGNATURE DATE

OPTIONS COUNSELING SERVICE, INC.
INFORMED CONSENT

CONFIDENTIALITY: Discussions between a Therapist and a client are confidential. No information will be released without your written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to: child abuse; abuse of the elderly or disabled; sexual exploitation; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

RECORDS AND YOUR RIGHT TO REVIEW THEM: As a client, you have the right to review, receive, or share a summary of your records at any time except in circumstances the Therapist feels releasing such information might be harmful in any way. Our policy is to keep records for 10 years. When more than one client is involved in treatment records will be released only with signed authorizations from all adults involved in treatment.

COUNSELING: The goal of *Options Counseling Service, Inc.* is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current Therapist are not a good fit, please discuss this matter with your Therapist to determine if transferring to a more suitable Therapist is right for you. If you and your Therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

While we expect change, there is no promise that this therapy will yield a positive result. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. We will likely to draw on various psychological approaches. These approaches may include, behavioral, cognitive-behavioral, cognitive, person-centered, system/family, developmental (adult, child, family) or psycho-educational. ***Options Counseling Service, Inc.*** **does <u>NOT</u> prescribe medications**.

Your first visit will be an assessment session in which you and your Therapist will determine your concerns, and if both agree that ***Options Counseling Service, Inc.*** can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you by your Therapist, services to you may be terminated.

EMERGENCIES: In the event of a counseling emergency during office hours, please contact our office directly. We will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours or on a weekend, please contact our office and a Therapist will call you back as soon as possible. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help.

SOCIAL NETWORKING: It is our preference to not accept friend requests from current clients on social networking sites.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

_____ _____

Signature – Client/Parent Date

_____ _____

Signature – Spouse/Parent Date

_____ _____

Therapist Date

OPTIONS COUNSELING SERVICE, INC.
415 W. Iowa Ave., Chickasha, OK 73018

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices. The notice states how we may use and/or disclose your health information.

Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print your name here

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

□ The patient refused to sign.

□ We weren't able to communicate with the patient.

□ Other (please provide specific details) _____

_____

_____ _____
Employee Signature Date

NOTICE OF PRIVACY PRACTICES

OPTIONS COUNSELING SERVICE, INC.

Pam Foster, Privacy Officer (405) 222-3018

Effective Date: September 23, 2013

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. ANY REFERENCES IN THIS DOCUMENT TO MEDICAL PRACTICE, MEDICAL RECORDS, MEDICAL SERVICES, ETC. APPLY ALSO TO PSYCHOTHERAPY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

TABLE OF CONTENTS

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart [and on a computer][and in an electronic health record/personal health record]. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

19. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

20. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

21. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

22. Fundraising. We may use or disclose your demographic information in order to contact you for our fundraising activities. For example, we may use the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status to identify individuals that may be interested in participating in fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Officer if you decide you want to start receiving these solicitations again.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint by using the form from the website below: www.hhs.gob/ocr/privacy/hippa/complaiants/hipcomplaint.pdf