ORLANDO COUNSELING SERVICES CONFIDENTIAL CLIENT INTAKE FORM

GENERAL INFORMATION

Date: _____ Referred by: _____

Full Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. _____

Nickname:_____ _____ Name You Prefer: _____

Social Security: _____ Age: _____ Date of Birth: _____

Race: ☐ White ☐ Black ☐Hispanic ☐ Asian ☐ Other: _____ Sex: ☐ Male ☐ Female

CONTACT INFORMATION

Street Address: _____ Suite/Apartment Number: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: ☐ Yes ☐ No

Mailing Address or Post Office Box: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: ☐ Yes ☐ No

Home Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Mobile Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Work Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Email Address: _____ May We Send Email Here: ☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked Per Week: _____

Average Annual Salary: ☐ $0 to $10,000 ☐ $20,001 to $40,000 ☐ $50,001 to $60,000 ☐ $80,001 to $100,000
☐ $10,001 to $20,000 ☐ $40,001 to $50,000 ☐ $60,001 to $80,000 ☐ More than $100,000

EDUCATION INFORMATION

Last Year of School Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

Are You Currently in School: ☐ Yes ☐ No. If Yes, What Level: _____ Degree Pursuing: _____

RELATIONAL INFORMATION

Current Relational Status: ☐ Single ☐ Dating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are You Content with Your Current Status: ☐ Yes ☐ No. If No, Briefly Explain: _____

If Married, How Long: _____ Number of Previous Marriages for You: _____ For Your Partner: _____

If Separated or Divorced, How Long: _____ If Widowed, How Long: _____

Partner's Name: □ Mr. □ Mrs. □ Ms. □ Miss □ Dr. □ Rev. _____

How Long Have You Known Your Partner: _____ Age: _____ Preferred Name: _____

Partner's Race: □ White □ Black □Hispanic □ Asian □ Other: _____ Partner's Sex: □ Male □ Female

Partner's Occupation: _____ Average Hours Worked Per Week: _____

Last Year of School Partner Completed: □ 9 □ 10 □ 11 □ 12 □ GED College: □ 1 □ 2 □ 3 □ 4 □ Other: _____

What Words Would You Use to Describe Your Partner: _____

Is Your Partner Supportive of You Seeking Counseling: □ Yes □ No □ Unsure □ Partner Doesn't Know

With Whom Do You Currently Live (*Check All that Apply*): □ Alone □ Spouse □ Children □ Parent(s) □ Sibling(s)
□ Boyfriend □ Girlfriend □ Roommate □ Other: _____

CHILDREN

List Your Children (Living or Deceased):

Name	Sex	Current Age or Year of Death	Relationship to You *(e.g. Natural, Adopted, Step)*	Living with You?	Describe Him/Her

Have You Ever Placed a Child for Adoption: □ Yes □ No. If Yes, When: _____

Have You Ever Had a Miscarriage or Medical Abortion: □ Yes □ No. If Yes, When: _____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members who Effected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You *(e.g. Mom, Dad, Sibling,Step)*	Occupation	Describe Him/Her

MEDICAL INFORMATION

Primary Physician: _____ Phone: (_____) _____

Address: _____ City: _____ Zip: _____

Specialty *(e.g. Family Practice, OB/GYN, Internal Medicine)*: _____

Are You Currently Receiving Medical Treatment: ☐ Yes ☐ No. If Yes, Please Specify: _____

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had *(Use Back if Necessary):* _____

_____

MEDICATIONS

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (Use Back if Necessary):

Medication: _____ Dosage: _____ ☐ Improves ☐ Prevents ☐ Controls: _____

Medication: _____ Dosage: _____ ☐ Improves ☐ Prevents ☐ Controls: _____

Are You Taking these Medication(s) According to Your Doctor's Recommendations: ☐ Yes ☐ No

If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

Headaches……..	☐ Past	☐ Present	Dizziness……..	☐ Past	☐ Present	Stomach Trouble….	☐ Past	☐ Present
Visual Trouble…….	☐ Past	☐ Present	Sleep Trouble……..	☐ Past	☐ Present	Trouble Relaxing….	☐ Past	☐ Present
Weakness……	☐ Past	☐ Present	Tension……	☐ Past	☐ Present	Rapid Heart Rate…	☐ Past	☐ Present
Difficulty Breathing..	☐ Past	☐ Present	Intestinal Trouble….	☐ Past	☐ Present	Hearing Noises……	☐ Past	☐ Present
Change in Appetite.	☐ Past	☐ Present	Tiredness……..	☐ Past	☐ Present	Pain……	☐ Past	☐ Present
Hearing Voices……	☐ Past	☐ Present	Seeing Things……..	☐ Past	☐ Present	Other……..	☐ Past	☐ Present

Your Height: _____ Your Weight: _____ How has Your Weight Change in the Last 2-3 Months: _____

CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You and/or Your Family:

Stress……	☐ Past	☐ Present	Nervousness……	☐ Past	☐ Present	Anxiety……..	☐ Past	☐ Present
Panic……	☐ Past	☐ Present	Unhappiness……	☐ Past	☐ Present	Depression…….	☐ Past	☐ Present
Guilt……..	☐ Past	☐ Present	Apathy……...	☐ Past	☐ Present	Terminal Illness…..	☐ Past	☐ Present
Recent Death……..	☐ Past	☐ Present	Grief……..	☐ Past	☐ Present	Hopelessness……..	☐ Past	☐ Present
Inferiority Feelings..	☐ Past	☐ Present	Defective Feelings..	☐ Past	☐ Present	Loneliness……	☐ Past	☐ Present
Shyness……	☐ Past	☐ Present	Fears……	☐ Past	☐ Present	Friends……	☐ Past	☐ Present
Marriage……	☐ Past	☐ Present	Communication……	☐ Past	☐ Present	Physical Abuse……	☐ Past	☐ Present
Emotional Abuse….	☐ Past	☐ Present	Verbal Abuse……..	☐ Past	☐ Present	Sexual Abuse……..	☐ Past	☐ Present
Temper……..	☐ Past	☐ Present	Anger……	☐ Past	☐ Present	Aggressiveness…...	☐ Past	☐ Present
Bad Dreams…….	☐ Past	☐ Present	Concentration……..	☐ Past	☐ Present	Racing Thoughts….	☐ Past	☐ Present
Unwanted Thoughts	☐ Past	☐ Present	Memory……	☐ Past	☐ Present	Loss of Control……	☐ Past	☐ Present
Impulsive Behavior.	☐ Past	☐ Present	Self-Control…….	☐ Past	☐ Present	Compulsivity…….	☐ Past	☐ Present
Sexual Problems….	☐ Past	☐ Present	Pregnancy……	☐ Past	☐ Present	Abortion……	☐ Past	☐ Present
Legal Matters……..	☐ Past	☐ Present	Trauma……	☐ Past	☐ Present	Eating Problems….	☐ Past	☐ Present
Drug Use……..	☐ Past	☐ Present	Alcohol Use……..	☐ Past	☐ Present	Trouble with Job…..	☐ Past	☐ Present
Career Choices……	☐ Past	☐ Present	Ambition……	☐ Past	☐ Present	Making Decisions…	☐ Past	☐ Present
Children……	☐ Past	☐ Present	Being a Parent……	☐ Past	☐ Present	Finances……..	☐ Past	☐ Present
Recent Loss…….	☐ Past	☐ Present	Disaster……..	☐ Past	☐ Present	Other……..	☐ Past	☐ Present

LEVEL OF DISTRESS

Indicate How Distressed You Are by Placing an "X" on the Scale Below *(1 = Very Little Distress; 10 = Extreme Distress)*:

1 2 3 4 5 6 7 8 9 10

Are You Currently Experiencing Any Suicidal Thoughts: ☐ Yes ☐ No. Have You Experienced Them in the Past: ☐ Yes ☐ No

Have You Ever Attempted Suicide: □ Yes □ No. If Yes, When and How: _____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: □ Yes □ No

If Yes, When and Who: _____

PRESENTING ISSUES AND GOALS

Please Describe Why You Are Coming to Counseling *(i.e. What Are Your Issues, Problems?):* _____

_____

Why Have You Decided to Come for Counseling Now: _____

_____

What Do You Hope to Gain or Change by Coming for Counseling: _____

_____

How Long Do You Believe Counseling Should Last: _____

PREVIOUS COUNSELING

List Any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received *(Use Back If Necessary):*

Therapist: _____ Location: _____ Dates: _____ Reason: _____

Therapist: _____ Location: _____ Dates: _____ Reason: _____

RELIGIOUS BACKGROUND

What Words Would You Use to Describe Yourself: _____

If God Were to Describe You, What Would He Say: _____

Briefly Describe the Religious Environment of Your Home as You Were Growing Up: _____

_____

Complete the Following Thought: God Is_____

Do You Regularly Attend a Place of Worship: □ Yes □ No. If Yes, Where: _____

What Is the Name of Your Pastor, Priest, Rabbi, or Other Spiritual Leader: _____

Do You Have a Personal Support System: □ Yes □ No. If Yes, Who: _____

TERMS OF SERVICE

I Understand that it Is Customary to Pay for Services when Rendered. I accept Full responsibility for Payment of Any Balance Incurred for Services. I further understand that without 24-Hour Notice of Intention to Cancel, I will be charged the Full Administrative Fee for Service.

Signed: _____ Date:_____

Orlando Counseling Services

I have read the ***Agreement*** **and** ***Office Policies and General Information*** carefully.
I understand them and agree to comply with them.

Print Client Name	Date	Signature
Print Client Name	Date	Signature
Print Client Name	Date	Signature
Therapist	Date	Signature

I have read the ***HIPPA Notice of Privacy Practices*** carefully.
I understand I may request a copy to keep.

Print Client Name	Date	Signature
Print Client Name	Date	Signature
Print Client Name	Date	Signature
Therapist	Date	Signature

Orlando Counseling Services

Consent to Treatment

This form is to document that I, _____, give my permission and
PRINT NAME

consent to the above named clinician to provide psychotherapeutic treatment to me and/or

_____, who is/are my child/children or for whom I am
PRINT NAME(S)

legal guardian, custodian, or legal Power of Attorney.

I understand the following:

- Although I expect benefits from this treatment, such benefits or particular outcomes cannot be guaranteed.
- Due to the counseling or therapy, I may experience emotional strains, feel worse during treatment, and make life changes that could be distressing.
- This therapist is not providing an emergency service, and I have been informed of whom to call in an emergency or during weekend and evening hours.
- Regular attendance will produce maximum benefits, but I am free to discontinue treatment at any time.
- Conversations with the therapist will be almost always confidential. However, the therapist, by law, must report actual or suspected child, spouse, or elder abuse to the appropriate authorities. The therapist also has a legal responsibility to protect anyone I may threaten with violence, harmful, or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. The therapist will make reasonable efforts to resolve these situations before breaking confidentiality.
- I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my health insurance.

I know of no reasons that I should not undertake this therapy and I agree to participate fully and voluntarily.

I have read and received the *Office Policies & General Information Agreement for Psychotherapy Services* and I agree to the policies. I have discussed any concerns about the policies with the therapist **prior** to signing this consent.

Signature:_____ Date: _____

Orlando Counseling Services

Confidential Client Information

Credit Card Payment Form

Date:_____

Client Name:_____

Address:_____

City, State, ZIP:_____

Contact Phone Number:_____

Payment Information: M/C VISA DISC AMEX Other:_____

Number:_____Exp:_____

ZIP:_____ CV number on back of card:_____

Amount: $35.00 for missed or cancelled appointments less than 24 hours notice

Signature:_____

I hereby authorize Orlando Counseling Services to charge this credit card for any and all services and amounts authorized by me, including appointments missed or cancelled less than 24 hours in advance. I understand that this paper will be retained by Orlando Counseling Services as my signed receipt for these transactions. I grant this authorization with the understanding that this form will be kept with my protected health information in my file in a fashion detailed by federal, state, local and industry-related guidelines and restrictions. This authorization is valid for the entire time I am receiving services from Orlando Counseling Services and/or its employees. I may, at any time, revoke my authorization to use this card as payment for services in writing to my therapist or Orlando Counseling Services at the following address:

Orlando Counseling Services
1817 Crescent Blvd., Suite 102
Orlando, FL 32817

OFFICE POLICIES & GENERAL INFORMATION
AGREEMENT FOR PSYCHOTHERAPY SERVICES

CONFIDENTIALITY:

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. (See Notice of Privacy Practices form)

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; and where a client presents a danger to self, to others, to property, or is gravely disabled.

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Debbie Haughton. In couples and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. The therapist will use his/her clinical judgment when revealing such information. The therapist will not release records to any outside party unless they are authorized to do so by all adult family members who were part of the treatment.

Emergencies: If there is an emergency during our work together, or in the future after termination, where the therapist becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, they will do whatever they can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, the therapist may also contact the person whose name you have provided on the intake sheet.

Health Insurance & Confidentiality of Records: Your health insurance carrier may require disclosure of confidential information *in order for you to file the claims*. If you so instruct us, only the minimum necessary information will be communicated to the carrier. The therapist has no control or knowledge over what insurance companies do with the information they submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information is entered into insurance companies' computers and soon will also be reported to the congress-approved National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question, as computers are inherently vulnerable to break-ins and unauthorized access. Medical data has been reported to have been sold, stolen, or accessed by enforcement agencies; therefore, you are in a vulnerable position.

Confidentiality of Cell Phone, Emails, Skype (and all other electronic communication) and Fax Communication: It is very important to be aware that unauthorized people can relatively easily access **cell phone** communication and hence the privacy and confidentiality of such communication can be compromised. **E-mails** in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. Thus, we do not communicate via email regarding therapeutic issues, though inquiry of information or general questions are acceptable, but not encouraged. It is best to leave a message in a confidential voice mailbox. Faxes can easily be sent erroneously to the wrong address. We will call prior to faxing and immediately following to insure confidentiality. Please notify us at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use faxes for emergencies, only fax the office after calling us first.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc. Neither you nor your attorney, nor anyone else acting on your behalf will call on a therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Special requests for letters and counseling records:

The therapist will only write letters for the client if:

a) it is written during a regularly-scheduled appointment;
b) the therapist is given at least 1 weeks' notice;
c) the therapist determines if the letter is within their level of expertise; and
d) the therapist determines, in his or her sole discretion, that such letter is appropriate.

Letters for FMLA, support animals, medical marijuana, college, etc. are some examples of letters that will be written at the therapist's discretion. If counseling records are requested and supplied, there will be a $10.00 charge per page.

Consultation: Therapists consult regularly with other professionals regarding his/her clients; however, the client's name or other identifying information is never mentioned. The client's identity remains completely anonymous and confidentiality is fully maintained.

Considering all of the above exclusions, if it is still appropriate, upon your request, the therapist will release information to any agency/person you specify unless the therapist concludes that releasing such information might be harmful in any way.

TELEPHONE EMERGENCIES:

If you need to contact your therapist between sessions, please call our office and leave a message on the confidential voice mail. Your call will be returned as soon as possible. We check our messages daily, unless out of town. If an emergency situation arises, please indicate it clearly in your message. If you are experiencing an emergency, please call 911.

PAYMENTS AND INSURANCE REIMBURSEMENT:

Clients are expected to pay the asking fee per 50-minute session at the end of each session. We accept cash, charge and checks. Checks should be **made payable to Orlando Counseling Services**. There is a $20.00 charge for returned checks. As a general rule, we do not charge for professional advice by phone for brief calls, **although those longer than 10 minutes** may be charged by the per hour rate. Please notify us if any problems arise during the course of therapy regarding your ability to make timely payments.

Sliding Scale: Because of the unique needs of our clients, we work on a sliding scale according to your financial needs and insurance reimbursements.

Our sliding scale will take into consideration both your financial situation as well as your potential insurance reimbursement. Our scale will start with the standard fee and slide down to an agreed upon amount. This is discussed on an individual basis only.

CANCELLATIONS:

Since scheduling of an appointment involves the reservation of time specifically for you, a **minimum of 24 hours notice** is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, A **$35.00 FEE** will be charged to your account without notification.

MEDIATION AND ARBITRATION:

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

The Process of Therapy/Evaluation: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Your therapist will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. Your therapist may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause your to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, your therapist is likely to draw on various psychological approaches according, in part, to the problem that is being treated and her assessment of what will best benefit you. These approaches include spiritual/biblical, behavioral, cognitive-behavioral, psychodynamic, existential, system/family, developmental (adult, child, family), or psycho-educational.

DISCUSSION OF TREATMENT PLAN:
Within a reasonable period of time after the initiation of treatment, the therapist will discuss with you their working understanding of the problem, treatment plan, therapeutic objectives, and their view of the possible outcomes of treatment. If you have and unanswered questions about any of the procedures used in the course of your therapy, their possible risks, the therapist's expertise in employing them, or about the treatment plan, please ask and you will be answered fully You also have the right to ask about other treatments for your condition and their risks and benefits.

DUAL RELATIONSHIPS:
Not all dual relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs the therapist's objectivity, clinical judgment, or therapeutic effectiveness or can be exploitative in nature. The therapist will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. The Central Florida community can be a small community in which many clients know each other and the therapist from the community. Consequently you may bump into someone you know in the waiting room or see your therapist out in the community. I will never acknowledge working therapeutically with anyone without his/her written permission. Dual or multiple relationships can enhance therapeutic effectiveness, but can also detract from it and often it is impossible to know that ahead of time. It is your responsibility to communicate to me if the dual relationship becomes uncomfortable for you in any way. I will always listen carefully and respond accordingly to your feedback. I will discontinue the dual relationship if I find it interferes with the effectiveness of the therapeutic process or the welfare of the client and, of course, you can do the same at any time.

TERMINATION:
As set forth above, after the first couple of meetings, we will assess if we can be of benefit to you. We will not accept clients who, in our opinion we cannot help. In such a case, we will give you a number of referrals that you can contact. If at any point during psychotherapy, we assess that we are not effective in helping you reach the therapeutic goals, we are obliged to discuss it with you and, if appropriate, terminate treatment. In such a case, we would give you a number of referrals that may be of help to you. You have the right to terminate therapy at any time. If you choose to do so, we will offer you names of other qualified professionals whose services you might prefer.

Orlando Counseling Services

HIPAA Notice of Privacy Practices

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

IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION *(PHI).* By law I am required to insure that your PHI is kept private. The PHI is information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. "Use" of PHI means when I share, apply, utilize, examine, or analyze information within my office; PHI is "disclosed" when I release, transfer, give, or otherwise reveal it to a third party outside my office. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use of disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to your PHI already on file. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may request a copy of this Notice from me at any time.

I am permitted to use and disclose your PHI without specific prior written authorization for the purposes of **treatment**, **payment**, and **health care operations**.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example would be providing your PHI to your insurance company for processing purposes.
- **Health care operations** include the business aspects of running the office, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

In addition, your PHI may be used without your consent or authorization for the following reasons:

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
4. If disclosure is compelled by the patient or the patient's representative pursuant to Florida Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.
5. To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.
6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
7. If disclosure is mandated by the Florida Department of Children and Families reporting law. For example, if I have a reasonable suspicion of child abuse or neglect.
8. If disclosure is mandated by the Florida DCF Elder/Dependent Adult Abuse reporting law. For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
10. For public health activities. For example, in the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. For health oversight activities. For example, I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. For specific government functions. For example, I may disclose PHI of military personnel and veterans under certain circumstances. Or in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.

14. For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.
15. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
16. I am permitted to contact you, without your prior authorization, to provide appointment reminders/confirmations or information about alternative or other health-related benefits and services that may be of interest to you.
17. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. For example, when compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
18. If disclosure is otherwise specifically required by law.

There are certain uses and disclosures that require you to have the opportunity to object, such as disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

Other uses and disclosures require your prior written authorization. In any other situation not described above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization in writing, to stop any future uses and disclosures (assuming that I have not taken any action subsequent to the original authorization) of your PHI by my office.

YOU HAVE CERTAIN RIGHTS REGARDING YOUR PHI

- The right to see and get copies of your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but know who does, I will advise you how you can get it. You will receive a response from my office within 30 days of receiving your written request. Under certain circumstances, I may feel that I must deny your request, but if I do, I will give you in writing the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, I will charge you not more than $0.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as the cost, in advance.
- The right to request limits on uses and disclosures of your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.
- The right to choose how I send your PHI to you. It is your right to ask that your PHI be sent to you at an alternate address (for example, your work address rather than your home address) or by an alternate method. I am obliged to agree to your request, providing that I can give you the PHI in the format you request without undue inconvenience.
- The right to get a list of the disclosures I have made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, such as treatment, payment, or health care operations, sent directly to you or your family; neither will the list include disclosures made for national security purposes to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years, unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including address, if known), a description of the information disclosed, and the reason forth disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which I will charge you a reasonable sum based on a set fee for each additional request.
- The right to amend your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone else. My denial must be in writing and must state the reasons for denial. It must also explain you right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and will advise all others who need to know about the change(s) to your PHI.
- The right to complain about my privacy practices. If, in your opinion, I may have violated your privacy rights, or if you object to a decision made about access to your PHI, you are entitled to file a complaint to me. You may also send a written complaint to: Secretary of the Department of Health and Human Services; 200 Independence Avenue S.W.; Washington, D.C. 20201