Family Solutions Counseling, PLLC

10400 N Vineyard Blvd, Ste. A
Oklahoma City, OK 73120
(405) 242-5305

Date of First Appointment: _____

BACKGROUND INFORMATION

Last Name: _____ First Name: _____ MI: ____

SSN: _____-____-_____ DOB: ___/___/___ Age: ____ Sex: ☐ M ☐ F Ethnicity _____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Address: _____ City: _____ State: ____ Zip: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

E-mail_____

Check if we can leave a message on your: ☐ Home phone ☐ Work Phone ☐ Cell Phone

EMERGENCY CONTACT (If client is under 18 or under legal guardianship, list Parent/Guardian)

Last Name: _____ First Name: _____ MI: ___

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work/Other Phone: _____ Relationship: _____

HEALTH CARE RESOURCES

☐ Private Insurance ☐ Public Insurance (Medicaid) ☐ None

Insurance Provider: _____

Policy/ID #: _____ Group #:_____

Policy Holder (name as it appears on the insurance card): _____

Policy Holder Date of Birth: _____

Policy Holder Employer:_____

_____

CURRENT LIVING SITUATION & FAMILY HISTORY

I live (check one): ☐ Alone ☐ w/Significant Other ☐ in Community Based Shelter

☐ Other: _____ Number of Persons in Home: _____

CHILDREN LIVING IN HOME (use back if needed)

Last Name: _____, First _____, MI ___ Age __ ☐ Male ☐ Female

Last Name: _____, First _____, MI ___ Age __ ☐ Male ☐ Female

Last Name: _____, First _____, MI ___ Age __ ☐ Male ☐ Female

Office use only: **Client Record #**_____ ☐ Check if shared file. Shared record #_____

OTHERS LIVING IN HOME (use back if needed)

Name: _____ Relationship to Client: _____

Name: _____ Relationship to Client: _____

CHILDREN LIVING OUTSIDE OF HOME (use back if needed)

Last Name: _____, First _____, MI ___ Age __ □ Male □ Female

City & State _____ If minor, with whom _____

Last Name: _____, First _____, MI ___ Age __ □ Male □ Female

City & State _____ If minor, with whom _____

PRESENTING PROBLEM/HISTORY OF PRESENTING PROBLEM

Who referred you? _____

Please write a couple of sentences concerning the reason for your request of services.

_____

_____

Please check your employment status ☐ Full-time □Part-Time □Unemployed □Not in Labor Force

If employed, who is your employer?

_____

What is the highest level of education you have received?_____

In the past 60 days, how many days have you or the minor been absent from school and/or daycare?

_____

Have you served in the military? ____ If so what is your current status? _____

Are you currently receiving any government assistance? ____ If so, what programs? _____

Please check all that apply □ Medicaid □ Medicare □ SSI □ SSDI

Are you currently using tobacco products? ___ If so, please describe your use. _____

How many days have you used tobacco in the past 30 days?_____

Are you currently using alcohol? ___ If so, please describe your use. _____

Are you currently using other substances? ___ If so, please describe your use. _____

How many times have you been in jail in the past 30 days?_____ 12 months?_____

Have you ever experienced (check all that apply): ☐ Physical Abuse, ☐ Emotional / Verbal Abuse, ☐ Sexual Abuse / Molestation / Sexual Misconduct, ☐ Neglect, ☐ I would rather not answer these

Have you ever attempted suicide? YES or NO

If "yes," identify month & year of attempt(s) _____

Have you ever had thoughts of suicide? YES or NO

If "yes," identify month & year of latest thought(s) _____

MEDICAL

Are you currently under the care of a physician for medical problems/medication? □ Yes □ No

If yes, describe: _____

Physician Name: _____ Phone: _____

Address: _____ City, State, Zip: _____

Are you currently taking medications? □ Yes □ No

If yes, list those you are currently taking (use back if needed):

	Medication	Strength & Dosage	Length Taken	Purpose & Side Effects
□	_____	_____	_____	_____
□	_____	_____	_____	_____
□	_____	_____	_____	_____

Please list any allergies:_____

Are you currently receiving behavioral/mental health services elsewhere? □ Yes □ No

If yes, provide the following:

Date	Type*	Where	Purpose/Diagnosis
_____	_____	_____	_____

* out-patient, in-patient, crisis intervention, day treatment, group, etc.

Have you received behavioral/mental health services in the past? □ Yes □ No

If yes, provide the following (use back if needed):

Date	Type*	Where	Purpose/Diagnosis
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How many self-help meetings have you attended in the past 30 days? _____

Please include any other information you feel is important for therapist to know.

_____

_____

_____

_____

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Policy Holder Employer:_____
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If employed, who is your employer?

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What is the highest level of education you have received?_____

In the past 60 days, how many days have you or the minor been absent from school and/or daycare?

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Have you served in the military? ____ If so what is your current status? _____

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If yes, describe: _____

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Address: _____ City, State, Zip: _____

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If yes, list those you are currently taking (use back if needed):

	Medication	Strength & Dosage	Length Taken	Purpose & Side Effects
□	_____	_____	_____	_____
□	_____	_____	_____	_____
□	_____	_____	_____	_____

Please list any allergies:_____

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_____	_____	_____	_____

How many self-help meetings have you attended in the past 30 days? _____

Please include any other information you feel is important for therapist to know.

_____

_____

_____

_____

Consent for Treatment

Statement of Professional Disclosure

You may access the laws and regulations which govern said professionals at the following websites:

LMFT, LPC: http://www.ok.gov/health/Protective_Health/Professional_Counselor_Licensing_Division/index.html.
LADC: http://www.okdrugcounselors.org/.

Right as a Client of Family Solutions Counseling

Please make sure you read and understand this and all forms.

Family Solutions Counseling (FSC) is comprised of the following therapists: Rebel Buersmeyer, LMFT, Carrie Kyger, LMFT, and Joshua Nichols, LMFT, as well as, candidates for licensure. Counseling services are voluntary. By signing this form, you acknowledge you are consenting to receive services necessary for yourself, your child and/or family, including diagnosis and treatment. FSC utilizes a team approach to treatment; therefore, as a client of FSC, you understand that our team approach to treatment may include case consultation, assessment, and treatment planning. By signing this form, you are also consenting to the possibility of your record being a "shared file" among multiple therapists at FSC. Whether or not to "share" your record will be determined on a case by case basis. Your consent to receive services does not waive your legal rights as recognized under Oklahoma law. Our conversations and your records are confidential. Information regarding your records or services is not available to anyone unless:

- You give your written permission on a release of information form.
- A court orders me to disclose records.
- A legal guardian gives written permission to release the information of a minor child.
- In an emergency situation when your personal safety or the safety of others may be threatened (Duty to Warn).
- There is a suspicion or report of abuse or neglect of children, elderly or disabled persons.

No Secrets Policy

As systemically trained therapists, we view the client, couple, and/ or family as the unit of treatment. Therefore, we adhere to a "no secrets policy" in our work. This means that your therapist may choose to NOT partake in "keeping secrets" from members of the therapeutic system. Thus, if you are partaking in couple's or family therapy, any information you disclose to your therapist may openly be discussed with other participating parties as part of treatment. Therefore, if you strongly desire to discuss matters other parties involved in therapy may or may not be aware of, and you desire to keep those matters secret, simply notify your therapist of this desire and s/he will set you up with an individual counselor to discuss the matters of concern.

You have a right to review all written reports about our work before they are sent/released.

It is further understood that your mental health insurance providers may request some records (e.g.) treatment plans or session notes in order to verify services and to assure the quality of services being provided. You will be informed when these circumstances occur. You have a right and responsibility to review these documents. Also be aware that peer consultation may occur between providers to assure services are appropriate and beneficial to you and/or your family.

You may request to have communication between therapist and your Primary Care Provider regarding evaluation and treatment information upon signing a release of information form. Upon request that your records be sent to another professional or agency, your wishes will be fulfilled with promptness upon receipt of your written request for information and provided there is no outstanding balance on your account.

Requested records may be protected under 42 C.F.R. Part 2, governing Alcohol and Drug Abuse patient records, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts. 160 & 164, State Confidentiality laws and regulations and cannot be released without your consent unless otherwise provided for by regulations. State and Federal law regulations prohibit any further disclosure of such records without your specific written consent or when otherwise permitted by such regulation.
As a client, you have the right to leave the premises at any time. You are not to be detained against your wishes unless you are a danger to yourself or others

Note: At least one parent or guardian must consent to the therapy of any minor children.

You have the right to refuse any service which you do not want and to discontinue any services you have already started. However, if you choose to discontinue treatment against professional advice, a notation to that effect will be placed in your records. In the event of court-ordered clients, the terms of the court may supersede this right.

It is the policy of Family Solutions to treat all clients and not to discriminate with regard to race, color, religion, national origin, age, sex, sexual orientation, gender identity or expression, or disability.

Counseling, Legal Issues, Court Reports and Testimony

Therapists are sometimes asked to provide counseling services to a child or family, whose parents or guardians are involved with legal disputes or challenges involving custody, visitation or other court related issues. The regulations and codes of ethics that therapists at FSC follow specifically describe how therapists legally may or may not conduct services in matters involving legal decisions.

If a child, adult or family is accepted as a client for counseling services, the therapist cannot be used as an expert witness for any forensic purposes. Therapists at FSC would only be able to serve as a "fact" witness in any legal report, deposition or testimony, therefore they could only provide factual information about services you received and only when the client and/or legal guardian gives her/his written permission to waive confidentiality. Waivers of privilege/ confidentiality must describe what specific information is to be released, to whom, for what purpose and for how long the release is valid. Factual witnesses may not offer any conclusions, opinions or recommendations. They can report X number of sessions were provided; a counseling plan was developed; the goals and objectives of the plan; and other "facts".

A fee will be charged for report writing, telephone consultations with attorneys, depositions, and court appearance and testimony. You can find the details such as the amounts charged for these services on the financial agreement.

Records and Emergency Procedures

Licensed Mental Health Professionals hold the confidentiality of records to the highest standards. Therefore, client confidentiality is protected upon his/her incapacitation from death or disability. Records will not be released to a third party unless a waiver is signed by the client. If your therapist becomes incapacitated from death or disability, your records will remain and be maintained by Family Solutions Counseling.

□ I would like to sign a waiver electing to release my records to a third party upon my incapacitation from death or disability.

Confidentiality of Electronic Communications and Social Media

Confidentiality of Electronic Communications includes, but is not limited to, E-mail, Cell Phone Communication, Text, and Social Media Websites. If you choose to e-mail your therapist, it is preferred that you do so by setting up an account via therapyappointment.com, which is encrypted and HIPAA compliant. Please call the office with help setting up your login. If you call your therapist, please be aware that unless you are both on landline phones, the conversation is not confidential. Likewise, text messages are not confidential. The landline number for your therapist is (405) 242-5305. **Please take note that FSC cannot guarantee confidentiality if you choose to email from your personal account or call or text from a cellular phone. The preferred method of communication is the app/ website OhMD or by landline phones.** OhMD is a confidential and HIPPA compliant app/ website. Please call the office with help connecting with your therapist. Family Solutions Counseling maintains several social media accounts. You are welcomed to utilize FSC's social media websites for purposes of education and keeping updated of event opportunities; however, confidentiality of friending, fanning, following, and interacting cannot be guaranteed. Your therapist will respond as soon as possible, but please allow your therapist 24 hours to return a phone call or message. If a life-threatening crisis should occur, you agree to call 911, go to a hospital emergency room, or call a crisis hotline: Oklahoma County Crisis Line at 405-522-8100, Suicide Prevention Hotline at 1-800-SUICIDE (1-800-784-2433), or Reachout National Hotline Crisis and Information Line at 1-800-522-9054

The recording of sessions on any electronic devices without prior consent from the provider is strictly prohibited.

Services

Family Solutions Counseling provides family, couples, group and individual therapeutic mental health and relationship services.

Your therapist offers traditional in-office therapy and/ or a variety of online and/ or distance therapy formats. You will be interviewed and may be asked to fill out some questionnaires to assist your therapist in determining how best to help you.

The duration of treatment is different for each person and can be difficult to estimate; your therapist will address any concerns that you have about this. If you are not feeling satisfied with your treatment for any reason, you are asked to discuss this directly with your therapist. They will work with you to uncover what might be preventing progress. Your therapist may modify goals with you if appropriate. Your therapist may also make a referral for you to (an) other professional (s) if necessary, and/or at your request. Sometimes people find that they have a temporary increase in their level of distress when beginning psychotherapy, because the process of working on personal issues can be difficult; please be aware of this.

Services do *not* include:

- Personality, ability, or vocational interest testing or evaluations.
- Custody evaluations and/or forensic reports
- Prescription of medications or treatment of problems for which medication or hospitalization may be the treatment of choice, such as major depression, suicidal intention, hallucinations, delusions, etc.

Emergency Services:
Family Solutions Counseling is not an emergency service. Therefore, in the event of an emergency, you are advised to contact the Oklahoma County Crisis Line at 405-522-8100, Suicide Prevention Hotline at 1-800-SUICIDE (1-800-784-2433, Reachout National Hotline Crisis and Information Line at 1-800-522-9054 , dial 911, or go to the emergency room of the nearest hospital.

What can you expect from Online Therapy

You as the client understand that phone and online sessions have limitations (as well as benefits) compared to in-person sessions, among those being the lack of "personal" face-to-face interactions, the lack of visual and audio cues in the therapy process, and the fact that insurance companies may not cover this type of therapy. **It is your responsibility to check with your insurance company concerning whether or not they will cover mental health treatment via online or telephone.** You understand that telephone/ online psychotherapy with your therapist is not a substitute for medication under the care of a psychiatrist or doctor. You also understand that your therapist follows the laws and professional regulations of the State of Oklahoma (USA). **You understand that online and telephone therapy may not be appropriate if you are experiencing a crisis or having suicidal or homicidal thoughts.** If a life-threatening crisis should occur, you agree to call 911, go to a hospital emergency room, or call a crisis hotline: Oklahoma County Crisis Line at 405-522-8100, Suicide Prevention Hotline at 1-800-SUICIDE (1-800-784-2433), or Reachout National Hotline Crisis and Information Line at 1-800-522-9054

Your therapist will make every effort to keep all information confidential. Likewise, if you are working online together, your therapist asks that you remove yourself from a public area and go to a secure location where you can participate in your session without fear of interruption and/or others listening in on your session. Your therapist also asks that you determine who has access to your computer and electronic information from your location. This would include family members, co-workers, supervisors, and friends. Your therapist encourages you to only communicate through a computer that you know is safe (i.e., wherein confidentiality can be ensured). Be sure to fully exit all online counseling sessions. If you are unable to connect or are disconnected during a session due to a technological breakdown, please try to reconnect within 10 minutes. If reconnection is not possible, call to finish your session via telephone or schedule a new session time.

If you need to speak with your therapist between sessions, please call (405) 242-5305. Your call will be returned as soon as possible. Messages are checked daily (but never during the nighttime). Messages are checked less frequently on weekends and holidays.

Coronavirus / Illness Policy

Family Solutions Counseling has taken steps to reduce the risk of the spread of the coronavirus and other illnesses within the office. FSC is following CDC guidelines in spacing chairs at least 6 feet apart, providing hand sanitizer at each entrance and exit, and cleaning high touch surfaces after each appointment. Additionally, you agree to the following steps to further help minimize exposure to illnesses.

- Come for your scheduled appointment only if you (and/or others coming to the appointment with you) are **not** exhibiting the following symptoms: fever, shortness of breath, sore throat, frequent sneezing, and/or coughing.
- For safety reasons, our waiting area may be closed. If that is the case, you can wait in your vehicle and notify your therapist of your arrival in the way you have been instructed to (e.g., OhMD app).
- Exit the building immediately after your scheduled appointment ends.

- Follow OKC mask madate.
- If you are found to test **positive** for COVID-19, please notify your therapist or practitioner immediately. If any therapists, practitioners, or other staff members on these premises tests positive for COVID-19, your therapist or practitioner will notify you by phone or confidential text (e.g., OhMD app) so you may take appropriate preventative steps.

By attending in-person therapy sessions, you agree to follow the above mentioned precautions, you understand the risks of contracting illnesses for yourself, your child/ children, and other family members in the course of receiving mental health services, you understand you or your therapist may request on-line therapy sessions, and you will not hold FSC responsible for contracting any illnesses during the course of treatment.

Payment for Services:

Payments for services must be made prior to the time of each session. Insurance often will not cover online therapy. You may make payment via check or credit card. Your therapist asks that you provide credit card information on the Credit Card Guarantee Form, which you agree to allow your therapist to charge for all balances.

Cancellation Policy:
As outlined in the financial agreement, you will be billed a flat rate of $100.00 if you miss an appointment or cancel without providing at least 24 hours notice.

****I have read the "Consent for Treatment" form and agree to the terms of consent. I understand and agree to the limits and conditions of therapy.****

Client Signature _____ Date _____

Client Signature (If applicable)_____ Date _____

Parent/ Guardian Signature (If applicable)_____ Date _____

Staff Witness _____ Date _____

You and your therapist will discuss this Consent for Treatment during your first session. If your sessions are scheduled online, please fax this form with signatures to (405) 242-5345, then snail mail the original to:

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OKC, OK 73120

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.

□ Due to an emergency situation, it was not possible to obtain an acknowledgment.

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

□ Other (please provide specific details) _____

_____ _____
Employee Signature Date

Office use only: **Client Record #**_____ □ Check if shared file. Shared record #_____

NOTICE OF PRIVACY PRACTICES

10400 N Vineyard Blvd, Ste. A
OKC, OK 73120

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:

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.

Appointment Reminders

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments. This service is provided as a courtesy. A 3rd party is used to handle these reminders, and although the delivery rate is at 99%, there are circumstances where messages will not be successfully delivered (if users are on the phone, out of service, etc). It is YOUR responsibility to record and keep any appointments that have been made, as we cannot guarantee you will successfully receive a reminder every time.

Online Appointment Scheduling

You can also enjoy the convenience of online scheduling at any time. Provide an email address to set up online scheduling. You will receive an email from TherapyAppointment with a link to create your Client Portal login. Once your account has been established, you simply visit **www.therapyappointment.com** and click on 'Find A Therapist' in the bottom center of the screen, type in your therapists full name (i.e. Joshua P Nichols, Carrie Kyger, Rebel Buersmeyer) to schedule or reschedule your appointments. You may continue to schedule appointments in person or by telephone; however, if you have Internet access, you are sure to enjoy the convenience of this online system.

Your name:_____

Your email address: _____

Your cell phone number: _____

Where would you like to receive appointment reminders? (check ONE)

_____ Via a text message on my cell phone (normal text message rates will apply)

_____ Via an email message to the address listed above

_____ None of the above. I'll remember my appointments on my own.

Note: Missed appointment fees will still apply

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private and requesting that it be handled as I have noted above.

Client Signature_____

Adverse Childhood Experience (ACE) Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt? ……,,,……..…..…..Yes No

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured? ……..……. Yes No

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you? ……..…….…….…..…Yes No

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?…….. Yes No

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?. Yes No

6. Were your parents **ever** separated or divorced? ……..……..……..…….. Yes No

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife? …….……Yes No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? …..…...…...Yes No

9. Was a household member depressed or mentally ill or did a household member attempt suicide?…...…….Yes No

10. Did a household member go to prison? ……..……..……...……...……. Yes No

Now add up your "Yes" answers: _____ This is your ACE Score

Office use only: **Client Record #**_____ ☐ Check if shared file. Shared record #_____