NEW PATIENT INFORMATION SHEET

Name _____; Male / Female
Last First Middle initial

Address _____

City _____; State ____; Zip _____; Birth date ____/____/____;

Home Phone (____) _____; Married / widowed / divorced / never married

May I mail to you at this address? Y / N; May I leave a message on your home phone? Y / N;

Cell Phone (____) _____; E-mail _____;

May I leave a message on your cell phone? Y/N; May I e-mail you? Y/N; May I text you? Y/N

REFERRED TO DR. CHAFETZ BY _____.

****

MEDICARE # _____; Insured is: Patient / Spouse / Other

US Federal Medicare? Y / N; Insurance company Medicare? Y / N; Part B coverage: Y / N

Medicare supplemental insurance company _____.

****

RESPONSIBLE PARTY (IF NOT PATIENT) _____

Address _____; Relation to Pt _____

City _____; State ____; Zip _____; Phone: H (____) _____;

May I mail to you at this address? Y / N; May I leave a message on your home phone? Y / N;

W (____) _____; E-mail _____; May I e-mail you? Y / N;

Cell (____) _____; May I leave a message on your cell phone? Y / N

Fax (____) _____; May I send you a message by fax? Y / N

****

I authorize the release of any medical or other information necessary to process all insurance claims. I authorize payment of government or other medical benefits to Dr. Chafetz. I agree to pay privately and in full (a) for sessions broken or cancelled without 24 hours advance notice, and (b) for services delivered which are not covered by Medicare.

INITIALS

X _____
SIGNATURE of insured or authorized person

X _____
DATE

TO: Paul K. Chafetz, Ph.D.

INDIVIDUAL PATIENT AUTHORIZATION REGARDING THE RELEASE AND USE OF PROTECTED HEALTH INFORMATION FOR BILLING AND PAYMENT PURPOSES

By signing this authorization form you agree to and authorize the release by your Health Care Provider of your Protected Health Information, as defined by the Health Insurance Portability and Accountability Act (HIPAA), and as described in this Authorization, for the purpose of your Health Care Provider receiving payment or reimbursement for services rendered to you.

This form does not authorize the release or communication of psychotherapy notes by your Health Care Provider to Professional Claims Administrators, the billing company referred to below.

1. Individual Patient (Or Personal Representative) Confirming The Authorization

I freely and voluntarily give my authorization to the Health Care Provider named above to use or disclose my Protected Health Information to Professional Claims Administrators, Inc. ("PCA"), a business associate of the Health Care Provider as defined by HIPPA, for the purpose of the billing and collection of charges for services rendered to me by the Health Care Provider named above.

Individual Patient's Name: _____ **Address:** _____

Telephone Number: _____ Social Security Number: _____

2. Authorized Use and/or Disclosure in Addition to 1. Through 6., above.

In addition to the items 1 through 6 above, I authorize the release, use and/or disclosure as is reasonably necessary for purposes of billing, payment and/or reimbursement: all necessary billing information, including but not limited to, date of birth, marital status, employer name, primary insured name, address & telephone number; primary insured insurance I.D. and group number; primary insured's employer name, hospitalization admission and discharge dates, dates of medical service provided, medical record number, procedure code, diagnosis code, name of referring physician, primary insurance payer's name, address, telephone and facsimile numbers; secondary insurance payer's name, address, telephone and facsimile numbers; third party administrator's and/or payer's name, address, telephone and facsimile numbers; and managed care authorization number. In the event my injury or illness is work related and subject to coverage by Texas Workers Compensation Coverage I authorize, in addition to the applicable information set out above the release of the date of injury, Texas Workers Compensation Commission identification number, and claim number.

The Health Care Provider named above is authorized to release and communicate to PCA and through PCA, as a business associate, my Protected Health Information as specified above for the purpose of the billing and collection and/or reimbursement of charges for services rendered to me by the Health Care Provider named above. In this regard PCA is authorized to release and communicate my Protected Health Information as specified above, for purposes of billing, collection and/or reimbursement of charges for services rendered to me by the Health Care Provider named above, to: myself, the Health Care Provider, insurance companies, third party administrators, health care clearinghouses, governmental agencies, including Medicaid and Medicare, self funded employer health care plans and/or self administered employers health care plans, the person(s) which I have specified below, and any other person or organization administering claims for payment and/or reimbursement of health care services related to the health care services provided to me. It is agreed and understood between the Health Care Provider, PCA and the individual patient signing this Authorization or the individual patient's representative that the Protected Health Information will only be released to such persons as may be necessary obtain to receipt of payment and/reimbursement for the health care services provided to the individual patient signing this authorization.

In addition to those person or entities, set out in the paragraph immediately above, to which I have authorized my Health Care Provider and PCA to release and communicate my Protected Health Information, as specified in the first paragraph of 2 above, I hereby authorize my Health Care Provider and PCA to release and communicate my Protected Health Information to the persons identified as follows: **(individuals other then patient inquiring about billing information)**

Name	**Address**	**Telephone**
Date of Birth	Social Security No.	Place of Birth
Name	**Address**	**Telephone**
Date of Birth	Social Security No.	Place of Birth

3. Terminating this Authorization

Select one of the following:

☐ This authorization terminates on the following date: _____

x This authorization terminates when one or more of the following events occur: I no longer receive health care services from the Health Care Provider named above, and/or PCA, Inc. no longer provides billing and collection services to the Health Care Provider named above.

4. Revoking this Authorization

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at the office of the Health Care Provider named above. However, I understand that a revocation of this authorization will not affect any actions taken prior to receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company may have a right to contest my claims under the insurance policy.

5. Signing This Authorization Is Not a Condition of Treatment

I understand that under most circumstances a Health Care Provider may not condition treatment, payment, enrollment, or eligibility for benefits upon my signing this authorization. I understand that signing this authorization is for the limited purpose of billing and collection of health care services provided to me by the Health Care Provider named above, and that the release, use, and/or disclosure of my Protected Health Information will be limited to the extent necessary to achieve such purpose.

6. Confirmation

I have had an opportunity to read and consider the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of my Protected Health Information described in this form with the people and/or organizations named and/or described in this form.

Signature:_____ **Date:** _____

If this authorization form is signed by a personal representative for the individual patient: Representative's Printed Name:_____

Signature: _____ Relationship to Individual Patient _____

YOU HAVE A RIGHT TO A COPY OF THIS FORM AFTER YOU SIGN IT.

A copy of this Authorization is to be maintained by the Health Care Provider Privacy Official, a copy included in the individual patient's medical record and a copy or the original forwarded to PCA concurrent with or prior to the release or communication of the individual's Protected Health Information.

Paul K. Chafetz, Ph.D.
Clinical Psychologist

8340 Meadow Rd., Suite 134
Dallas, TX 75231
469-233-5566

Fax 214-378-7009
pkchafetz@sbcglobal.net
PaulKChafetz.com

COMBINED AGREEMENT

Includes:

1. **Psychologist-Patient Services Agreement**
2. **Authorization to Release Information**
3. **Acknowledgement of receiving HIPAA Notice**

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully, and discuss with me any questions you have.

When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless (a) I have taken action in reliance on it, (b) there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy, or (c) you have not satisfied any financial obligations you have incurred.

PURPOSE, GOALS, AND NATURE OF SERVICES
(Choose Evaluation, Treatment, and/or Consultation)

A. _____ EVALUATION

The purpose of an evaluation is to accurately assess the patient's mood, thinking ability, and behavior. The evaluation is conducted at the request of the patient, or someone (often a relative or a health professional) who both (a) knows the patient and (b) has specific concerns about the patient's wellbeing, clinical psychological needs, suspected impairment or disorder, or need for care.

This evaluation will gather data about the patient's past and current psychological functioning. Procedures may include (a) review of patient's medical chart, if available, (b) discussion with a knowledgeable relative of the patient, staff of the patient's residential or care setting, and/or other health care personnel, and/or (c) interviewing of, and administration of standardized psychological assessment procedures to, the patient. Based on the information gathered, I will form an opinion about the situation (diagnostic impressions), and make treatment recommendations. When appropriate, and with permission of the patient or his/her representative, I will share my findings and recommendations with concerned individuals, who may include the patient's physician, relatives, facility staff, or other caregivers.

A single evaluation, which will involve one to several hours of the patient's time, is anticipated. Upon later request, due to continued or new concerns, briefer follow up reevaluations may be conducted as indicated.

_____ Patient's initials

B. _____ PSYCHOLOGICAL TREATMENT

The primary purpose of psychological treatment is to decrease symptoms of mental disorder. Additional goals may include relieving distress, improving mood or emotional wellbeing, clarifying goals, increasing insight, identifying and mobilizing resources, and increasing coping skills.

Psychological treatment, often called psychotherapy, typically occurs in the context of 45-minute sessions. Sessions are usually held on a weekly basis initially, and then less frequently as the patient begins to achieve his/her goals. Sessions may involve my meeting (a) with the individual patient only, (b) with the patient and key relatives or caregivers, or (c) with key relatives or caregivers only (to discuss management of the patient's symptoms). During sessions, conversation typically deals with the patient's feelings, thoughts, activities, behaviors, resources, problems/challenges, history, and relationships with people. I will work to create a safe and respectful setting in which the patient can openly discuss these issues, to assist the patient to achieve the purposes and goals listed above. The recommended duration of treatment will be discussed with the patient individually. When appropriate, and with permission of the patient or his/her representative, I will share his findings and recommendations with concerned individuals, who may include the patient's physician, relatives, facility staff, or other caregivers. Dr. Chafetz reserves the right, until the fifth session, to terminate the treatment relationship if he believes that the patient will not benefit from Dr. Chafetz' services.

C. _____ PSYCHOLOGICAL CONSULTATION

The primary purpose of psychological consultation is to discuss a friend or loved one about whom the patient is concerned. That friend or loved one may or may not be known to Dr. Chafetz. The consultation is an effort to find new and more helpful ways for the patient to (a) understand the situation, (b) act in the situation, and (c) evaluate progress in the situation.

CONTACTING ME

My business phone number rings directly to my cell phone. When I am in session or otherwise unavailable, you will reach my voice mailbox. I will make every effort to return your call on the same day, except on weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

It is my policy to NOT discuss sensitive patient information by e-mail, text, or voicemail.

SITUATIONS THAT MAY LEAD TO IMMEDIATE OR PREMATURE TERMINATION OF OUR PATIENT-PSYCHOLOGIST RELATIONSHIP

You are hereby informed, and you agree, that the following occurrences or situations give me (Dr. Chafetz) the authority to stop providing psychological services to you, as well as other individuals you may have involved in your therapy, and that such termination of the patient-psychologist relationship does not constitute abandonment:

(a) nonpayment of fees due for services rendered;
(b) repeated missed appointments or late cancellations;
(c) failing to respond to Dr. Chafetz' phone or mail contacts for two weeks.
(d) adversarial legal or financial relationship with me or anyone associated with me through family, business, or organizational ties;
(e) threats or demonstration of violence toward me or anyone associated with me through family, business, or organizational ties;
(f) criminal activity by the patient; or
(g) bringing a weapon into the building containing Dr. Chafetz' office.

_____ **Patient's initials**

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. Your signature on this Agreement provides consent for release in certain additional situations, including: Clinically necessary consultation with other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- I have contracts with an electronic billing firm and a typing service. As required by HIPAA, I have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this information, except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract. In addition, Dr. Chafetz uses electronic and internet based means of charging credit cards and of maintaining his calendar, the security of which is subject to internet factors out of Dr. Chafetz' control. You consent to Dr. Chafetz using these electronic and internet services.

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

- If a patient seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection. Texas law provides that a professional may disclose confidential information only to medical or law enforcement personnel, if the professional determines that there is a probability of imminent physical injury by the patient to the patient or others, or there is a probability of immediate mental or emotional injury to the patient.

Situations in which I am permitted or required to disclose information without either your consent or authorization include:

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

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

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

- If a patient files a worker's compensation claim, I must, upon appropriate request, provide records relating to treatment or hospitalization for which compensation is being sought

_____ **Patient's initials**

Situations in which I am legally obligated to take actions which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment, include:

- If I have cause to believe that a child under 18 has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, the law requires that I make a report to the appropriate governmental agency, usually the Department of Protective and Regulatory Services. Once such report is filed, I may be required to provide additional information.

- If I determine that there is a probability that the patient will inflict imminent physical injury on another, or that the patient will inflict imminent physical, mental, or emotional harm upon him/herself or others, I may be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the patient.

In such situations, I will make every effort to fully discuss it with you before taking any action, and I will limit my disclosure to what is necessary.

THERAPY WITH COUPLES OR FAMILIES

When patients enter family or couples therapy, they waive their right to confidentiality among the therapy participants. It is not therapeutically advisable for the therapist and one partner or family member to hold confidential information from the other partner or family members. This does not mean that Information will be automatically shared by Dr. Chafetz. However, patients are strongly encouraged to share pertinent information as necessary to facilitate the benefits of therapy. Do not tell Dr. Chafetz anything you do wish to be kept secret from your prater or family members, as Dr. Chafetz reserves the right, at his discretion, to share any information he deems helpful to therapy.

Patients in couples or family therapy with Dr. Chafetz understand and agree that Dr. Chafetz is not responsible for the consequences of therapy. That is, if therapy is followed by divorce, for example, the participating patients understand and agree that the causes of this pre-dated therapy with Dr. Chafetz, and that the therapy did not cause it. Further, all patient participants in the therapy agree to not subpoena, or cause to be subpoenaed, Dr. Chafetz or his records under any circumstance, in the course of any legal proceedings. They also understand and agree that no patient participant can obtain, or give permission to share with another party, any information from the therapy, including written records, without the valid written permission of all participating patients.

PROFESSIONAL RECORDS

Pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Under Texas law, psychological test data are not part of a patient's record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. You will be charged a copying fee of $1 per page and for related expenses. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your Clinical Record, you have a right of review, which I will discuss with you upon your request.

In addition, I sometimes keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from patient to patient, they can include the contents of our conversations, my analysis of those

conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes unless I determine that release would be harmful to your physical, mental or emotional health.

In compliance with state law, I maintain records for ten years following the latest contact with a patient.

With your signature on this consent form, you acknowledge that, in the event of Dr. Chafetz's death or incapacity, it will be necessary for another person to take possession and control of you file and your records. You give consent to allow another psychologist, selected by Dr. Chafetz, to take possession and control of your file and records, and to provide you with copies or to deliver them to a mental health provider of your choice, upon your written request and payment of reasonable administrative costs.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include (a) requesting that I amend your record, (b) requesting restrictions on what information from your Clinical Record is disclosed to others (c) requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized, (d) determining the location to which protected information disclosures are sent, (e) having any complaints you make about my policies and procedures recorded in your records, and (f) the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures.

FINANCIAL POLICIES

A. _____ FEDERAL MEDICARE BENEFICIARIES

I am an independent health care provider under the federal Medicare program, Part B. Therefore, I accept Medicare assignment, which means that charges are limited to those allowed by Medicare. My billing service will file all necessary claims with both Medicare Part B and the patient's supplemental insurance. If your insurance benefits run out before you feel ready to end your sessions, you always have the right to continue to receive my services, as a private-pay patient. Fees for services that are not covered by Medicare are consistent with community standards. Please note that you (not your insurance company) are responsible for full payment of fees. Medicare replacement policies through private insurance companies are not accepted. Patients who do not use the federal Medicare program, Part B, hereby agree to privately pay all fees for services provided. Patients are responsible for full payment for appointments that are missed or are cancelled with less than 24-hour notice. Neither Medicare nor insurance pays these charges. Patients who use Medicaid as their Medicare supplement agree that two missed or late cancelled appointments constitute grounds for termination of the treatment relationship by Dr. Chafetz.

B. _____ ALL OTHER PATIENTS

Fees are payable at the time of service. Your clinical fee per 50 minute session is $ _____. Your regular fee will be charged for any additional professional services rendered at your request, such as phone contacts over five minutes, consultations with other professionals, etc.

Your visits are reserved for you. Twenty-four hour notice is required for cancellation, or you will be charged for the session.

Other service, such as report writing, telephone conversations lasting longer than five minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me, will be billed at the rate shown in the above paragraph.

_____ **Patient's initials**

I will provide you a written receipt for all charges, in a format which includes all information required for processing by insurance companies. It is your responsibility to forward these forms to your insurance company, if you wish to request insurance reimbursement. You are responsible for payment for services regardless of your insurance company's reimbursement policies.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

Your contract with your health insurance company may require that I provide it with information relevant to the services that I provide to you, such as a clinical diagnosis, treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum necessary information about you. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

PROFESSIONAL FEES FOR PRIVATE PAY SERVICES

Other service, such as report writing, telephone conversations lasting longer than five minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me, will be charged to your account at the clinical fee rate stated above.

If you become involved in legal proceedings that require my participation, you agree to pay for all of my professional time, even if I am called to testify by another party. Such services include preparation, consultation, attendance at any legal proceeding, providing testimony or deposition, and transportation costs. My fee for these services is $225.00 per hour.

* *

The patient or legal representative has the right to revoke this authorization at any time by sending written notification to Dr Chafetz's office address. However, such revocation will not be effective to the extent that Dr. Chafetz has taken action in reliance on the authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. The patient or legal representative understands that Dr. Chafetz generally may not condition psychological services upon authorization to release of information, unless the psychological services are provided for the purpose of creating health information for a third party. The patient or legal representative understands that information used or disclosed pursuant to the authorization may be re-disclosed by the recipient, and may no longer be protected by the HIPAA Privacy Rule.

The undersigned further acknowledges receiving the attached HIPAA Notice Form described above.

____________ **Patient's initials**

Name of patient

Name of patient's legal representative

This patient or legal representative has read, and understands and agrees to, the above information regarding the services of Dr. Chafetz.

Further, the patient or legal representative authorizes Dr. Chafetz to obtain information about this patient from, and release the following specific information (unless crossed out here), about this patient:

History; Findings; Medications; Recommendations; Outcomes; Other _____, to

1. _____
Primary physician Phone

_____
Address Zip

2. staff of the patient's health care or residential facility, and patient's insurance companies, and

3. Others (name & address)

_____

_____

_____

_____

_____

The patient or legal representative is requesting Dr. Chafetz to release or obtain this information:

____ To facilitate quality psychological care for the patient, or

____ Other reason: _____

Authorization expiration (date or event):

_____

X _____
Signature of Patient OR legal representative*

X _____
Date

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

Paul K. Chafetz, Ph.D.
Clinical Psychologist

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PaulKChafetz.com

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

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

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

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

- "*PHI*" refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my office, clinic, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

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

- **Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.

- **Adult and Domestic Abuse:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.

- **Health Oversight:** If a complaint is filed against me with the State Board of Examiners of Psychologists, they have the authority to subpoena confidential mental health information from me relevant to that complaint.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.

- **Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

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

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

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

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

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

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

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide the revised policies and procedures to you by mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me at the address or phone number shown on page one.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on June 1, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail.