VIRGINIA FAMILY COUNSELING

DATE:

CLIENT INFORMATION

(If client is a couple, please list info for both; if client is a child, please list info for child except employer, phone numbers, and marital status info.)

PRIMARY CLIENT

CLIENT # 2 (IF COUPLE)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS

CITY STATE ZIP

EMPLOYER

POSITION

HOME TELEPHONE (Put \* next to #s where message can be left

BUSINESS TELEPHONE

CELL PHONE

EMAIL ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH AGE

MARITAL STATUS

For Therapist Use Only

DSM:

CURRENT AND PREVIOUS MARRIAGES (include years):

WHO IS LIVING IN YOUR RESIDENCE?

Name Age Relationship

CHILDREN NOT LIVING AT HOME (names and ages)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason that you are here**:

Briefly describe the problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did the problem start and has something in particular happened or changed recently that led you to seek professional assistance **at this time**?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe personal or family history of mental health problems, suicidal thoughts, attempts, or completed suicides, mental health/substance abuse hospitalization dates/place.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe briefly any serious medical problems and/or medications for you or anyone in the family.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list name and phone number of attending physician. May we call to coordinate care?\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any concerns about the ways you or anyone in your family use alcohol or other substances

or how anyone expresses anger? Please describe.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_

Please list names, dates of previous/current therapists or psychiatrists.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been involved in or do you expect to be involved in litigation or legal issues? If yes, explain briefly.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who can we contact in the event of an emergency? Please give name and relationship with home and

work numbers.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRED BY: \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Information and Informed Consent**

Welcome to Virginia Family Counseling! Thank you for choosing our practice and trusting us with your important life issues. We look forward to collaborating with you on your journey toward increased well –being. In the interest of providing a smooth process and minimizing confusion, we have created the following policies. Thank you for taking the time to carefully review them.

 All therapists here are independent contractors licensed to practice psychotherapy in the state of Virginia and not employees of VFC. As such, each therapist is solely responsible for decisions regarding treatment, fees, and schedule and will discuss these with you. While no specific outcomes can be guaranteed, in order for therapy to be most effective, you will have to work on things you and your therapist talk about both during and after sessions. Exactly what changes will look like is unknown and things can sometimes feel worse before they feel better. The following are policies and procedures that all therapists agree upon; please discuss any questions you may have with your therapist.

**Services and Emergencies:**

The first 2-4 sessions will involve an evaluation of your needs, after which you and your therapist will discuss how to proceed. Each session lasts 50 minutes. The ten minutes between sessions is for transition and therapists will not be available during that time. **48-hour cancellation is required to avoid being charged for the missed session.**  Insurance companies do not usually reimburse for broken appointment fees. Other professional services that you may require such as report writing, phone calls longer than 15 minutes, attendance at meetings or consultations that you have requested, or the time required to perform any other service which you may request, will be charged on a prorated basis. Although every effort will be made to assist you during a crisis, neither VFC nor your therapist is an emergency or crisis provider. If you are having a mental health crisis or emergency, you are hereby agreeing to call 911 or go to your nearest emergency room.

**Initial here agreeing to policies concerning services and emergencies** \_\_\_\_\_\_\_

**Confidentiality and Limits of Communication:**

Confidentiality is maintained in accordance with generally accepted ethical standards. Case consultation occurs within VFC for the benefit of our clients. Policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. Electronic communication including, but not limited to, email, text, and phone communication are not HIPAA compliant, and therefore confidentiality cannot be guaranteed. These forms of communication should be limited to administrative issues such as scheduling or billing; your therapist may make exceptions. Therapists at VFC do not accept friend requests from clients on Facebook, LinkedIn, or other social media platforms.

**Initial here agreeing to policies concerning confidentiality, privacy, and limits of communication** \_\_\_\_\_\_\_

**Fees:**

**Payment is due at the time of the session.** Fee increases may occur in January of each year. Payment can be made by cash, check, Visa, or MasterCard. Checks should be made out to **Virginia Family Counseling.** A fee of $35 will be billed to you for any returned check. All missed appointments and unpaid balances will be automatically charged to your credit card. If your account is overdue by 60 days, we reserve the right to share your confidential billing information with a collection agency in order to collect payments. All therapists at VFC are out-of-network for insurance at this practice but will provide you with a monthly statement containing all the information commonly requested by insurers. It is your responsibility to submit claims and to follow up with your insurer; third party reimbursement cannot be guaranteed. No therapist at VFC is a Medicare provider. Please tell your therapist if you receive Medicare.

 **Initial here agreeing to policies concerning fees** \_\_\_\_\_\_\_

**Legal Representation:**

Information discussed in therapy is for therapeutic purposes and is not intended for use in any legal proceedings. Therefore, therapists at VFC do not appear in court unless subpoenaed. Please discuss with your therapist at the outset if you are or may be court involved. If subpoenaed by any party in a legal proceeding involving you, testimony in person or in writing will follow HIPAA guidelines and incur a charge of $2,000 per day for any part of an 8-hour day. Other related expenses will be billed at $400/hr. If your therapist believes he/she requires legal counsel, you will be billed for that at cost.

**Initial here agreeing to policies concerning legal representation \_\_\_\_\_\_\_**

**Termination of Treatment:**

You and your therapist will decide together when your goals have been met and it is time to terminate therapy. You are, of course, free to terminate therapy at any time. You are strongly encouraged to tell your therapist if you are considering terminating and to come in for a final session. If you are unhappy with what is happening in therapy, we hope you will talk with your therapist. Such comments will be taken seriously and handled with care and respect. You therapist reserves the right to terminate therapy if you do not comply with his/her recommendations in such a way that you put yourself or others at risk, or such that your therapist believes that he/she cannot be of further help to you. If 30 days pass after your most recent session and you have not contacted your therapist, your case will be closed.

**Initial here agreeing to policies concerning termination of treatment \_\_\_\_\_\_\_**

\*Please be aware there is a therapy dog on the premises; if you have any animal-related issue, please discuss with your therapist.

**WE ARE HAPPY TO DISCUSS ANY OF THE ABOVE ITEMS WITH YOU.**

Your signature below will verify that you have read the information regarding policy and fees and the Notice of Privacy Practices and are consenting to undergo treatment and to follow all business practices outlined in this agreement. If the client is a couple, both signatures are required; if the client is a child, and parents are divorced, both signatures are required unless one parent has sole custody, in which case, please provide a copy of the custody agreement to keep on file. Thank you for choosing Virginia Family Counseling!

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Signature (if applicable) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Signature (if applicable) Date

**CREDIT CARD AUTHORIZATION**

Please complete this form even if you will not be charging your sessions on a regular basis. Because clients may occasionally forget to leave payment, we appreciate having a card on file which will not be charged without notifying you.

\_\_\_\_\_\_\_\_\_(Initial) I authorize Virginia Family Counseling to keep my signature on file and to charge my account for services rendered including late cancellation, no show charges, and unpaid balances.

 I understand that this form is valid for four (4) years unless I cancel the authorization through written notice to Virginia Family Counseling.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Holder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Holder’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Visa \_\_\_\_\_ MasterCard

Account #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CVV2: \_\_\_\_\_\_\_\_\_\_ (3 digits found on the back of the card in the signature line)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### YOUR COPIES FOR YOUR RECORDS

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**CRISIS RESOURCES**

Because VFC is not a crisis center, we have included a list of crisis centers that you can call for emergency services in addition to your local emergency room here for your convenience. These are:

1. Fairfax Cty Mental Health: 703-573-5679
2. CSB Emergency Services: 703-573-5679
3. Crisis Link Hotline: 703-527-4077
4. Fairfax Detox Center: 703-502-7000
5. Loudoun Cty Mental Health Emergency: 703-777-0320
6. Prince William Cty CSB Emergency: 703-792-7800

**NOTICE OF PRIVACY PRACTICES**

Effective September 2013

**This notice describes how medical/mental health information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.**

***Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act (“HIPAA”), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.***

*We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.*

**Uses and Disclosures for Health Information about you.**

**For Treatment**--Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

**For Payment**--We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

**For Health Care Operations**--We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

**Required by Law--**Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

**Without Authorization**--Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

**Uses and Disclosures without Authorization**

**Child Abuse or Neglect**--We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

**Judicial and Administrative Proceedings**--We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

**Deceased Patients--**We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person’s estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

**Medical Emergencies--**We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

**Family Involvement in Care--**We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

**Health Oversight--**If required,we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

**Law Enforcement--**We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

**Specialized Government Functions--**We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

**Public Health--**If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

**Public Safety--**We may disclose your PHI ifnecessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

**Research--**PHI may only be disclosed after a special approval process or with your authorization.

**Fundraising**--We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

**Verbal Permission--**We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

**With Authorization**--Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

**Patient Rights**

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer Tracy Ryan Kidd, LCSW:

**Right of Access to Inspect and Copy**--You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a “designated record set”. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

**Right to Amend**--If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

**Right to an Accounting of Disclosures**--You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

**Right to Request Restrictions**--You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

**Right to Request Confidential Communication**--You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

**Breach Notification**--If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

**Right to a Copy of this Notice**--You have the right to a copy of this notice.

**Complaint Procedure**

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer Tracy Ryan Kidd, LCSW or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**