A Better Day

Adult

Behavioral Medicine Patient Registration

Please fill out the following information completely

Patient Name_____ Date _____ Age_____

DOB: _____ Male_____ Female_____ Social Security #_____-_____-_____
(Required)

Mailing Address _____City _____ Zip_____

Home Address _____ City _____ Zip_____
(If different from mailing address)

Home Phone _____ Cell Phone _____

Marital Status: S M D W How Long? _____ Previous Marriage(s) Yes / No Give Dates: _____

Race: _____ Decline_____ Ethnicity: Hispanic_____ non-Hispanic _____Decline _____

Primary Language Spoken: _____

Religious Preference (optional) _____ Military Service _____ Referred By_____

Employer_____Occupation_____ Years Employed _____

Employer Address_____ Work Phone # _____

Spouse Employer_____Work Phone # _____

Primary Physician_____Phone #_____

Email _____

Emergency Contact Person _____ Relation_____ Phone _____

INSURANCE INFORMATION

Primary Insurance Co. _____Insurance I.D. # _____

Name of Policyholder/Sponsor_____SS#_____-_____-_____D.O. B_____

Employer_____ Group # _____

Secondary Insurance Co. _____Insurance I.D. # _____

Name of Policyholder/Sponsor_____SS#_____-_____-_____D.O. B_____

Employer_____ Group # _____

Office Policies and Financial Contract with Consent for Treatment

Welcome to our practice. We want your psychological needs to get the best and most efficient attention possible. A sound relationship between patient and therapist is based on a mutual understanding of these general office policies and the fees and financial arrangements involved. Sessions are by appointment only. After office hours, please leave a voicemail to re-schedule or cancel an appointment.

Treatment Philosophy

Outpatient psychotherapy consists of face-to-face contacts between a licensed professional and patient, and may include individual, group, family, short- or long-term therapy, crisis intervention or medication consultation. If your contract is with managed care, therapy will be brief and problem focused. You will be expected to participate in setting and achieving treatment goals.

A Case Manager oversees your number of sessions and will request information about your therapy. You will be asked to sign a release of confidential information for that purpose.

Attendance and Cancellation Notice

Regular at tendance is necessary to receive the maximum benefit possible from treatment. Appointments are generally 45 minutes long and are reserved for you in our calendar. It is customary and reasonable to require that you give a **24-hour notice for a cancellation** of a scheduled appointment. You will be held liable for the full contracted rate of up to **$150.00** for broken appointments giving l ess than 24-hours' notice. Managed care and insurance companies cannot be billed for these cancellation fees. A pattern of failure to keep appointments or failure to give 24-hour notice to cancel may be terms for off-schedule and/ or discontinuation of treatment according to our policy. **(Please initial_____)**.

Financial Contract, Deductibles, and Co-payments

You are responsible for obtaining prior authorization from your insurance or managed care company prior to treatment. If this office accepts your insurance or we are contracted with your care company, you are responsible for the co-payment amount and the deductible as set by your benefit plan. Your contracted fee for the initial assessment is **$200.00.** Each follow up session is **$150.00.** If for any reason your insurance company does not pay these contracted rates, you will be held accountable for paying your balance. **(Please initial_____)**.

Co-payment amounts are set by your benefit plan. These payments are due and payable at the beginning of each appointment. If you desire services not provided by your managed care company or benefits beyond your benefit contract, you will need t o sign a separate written contract with this office. **(Please initial_____)**.

Telephone Calls

If there should occur a time where essential concerns must be discussed on the telephone, the Provider charges at the same rate as the contracted rate above, based on the amount of time spent on the telephone. These charges will be your personal expense if they cannot be billed to your insurance company. **(Please initial_____)**.

Limits Of Confidentiality

All information and records obtained during the course of treatment shall remain **confidential** and will not be released short of a signed written consent. The legal exceptions to your confidentiality are as follows:

(1.) If a therapist believes that a patient intends to eminently commit serious bodily harm to another identifiable person or persons, it is the therapist's duty to warn the person or persons of intended harm as well as the authorities (Tarasoff v s. Regents of University of C al., 1976).

(2.) If a therapist believes that a patient intends to eminently commit serious bodily harm to himself, it is the therapist's duty to take necessary action to protect the individual, which may include notifying authorities (Johnson v. County of Los Angeles, 1983).

(3.) If a patient becomes involved in certain kinds of very important court cases, a judge may subpoena records and/or testimony. This is rare, but the therapist's ability to shield confidentiality in these cases may be compromised and varies from case-to-case.

(4.) If a therapist suspects that a child, elder, or dependent adult either is currently being abused, or has been abused in the past (where there i s a risk of r e-offense), and the authorities don't already know about it, it is the therapist's duty t o inform the authorities (Welfare & Institution Codes, Penal Codes Section 11165, 11166 and others).

Releases of Information

Certain insurance companies (Medicare) and managed care companies ask us to get a release to the primary care physician to coordinate care. You may refuse this request or you can allow it. You will be asked if you wish to sign a release of confidentiality form.

If you are electing to use your insurance or managed care benefits, you will be required to sign a release of confidential information to your benefit plan so as to process claims for certification, case management, quality assurance, benefit administration and other purposes such as utilization. If you do not want such information to be shared with your benefit plan, you may pay privately without using your insurance company.

Consent for Treatment

I authorize and consent to treatment, which may include various psychological assessment techniques, psychological exams, diagnostic procedures, and psychotherapeutic services. I understand that while psychotherapy is intended to be helpful, no guarantees as to outcome can be made. The psychotherapeutic process can cause a person to experience unpleasant emotions, feelings and reactions such as anxiety, sadness, and anger. These responses are normal, if they should occur, and I agree to work through these responses with my therapist.

I accept and consent to the office policies, financial arrangements, as well as the terms of each of the foregoing paragraphs of this contract.

Patient Name _____

Patient Signature _____ Date _____/_____/_____

Therapist Signature _____ Date _____/_____/_____

Policy Regarding Missed, Late, or Cancelled Appointments

When I miss a scheduled appointment and do not cancel the appointment at least 24 hours in advance, I understand that I will be charged for that broken appointment. It is my personal expense and the Insurance Company or Managed Care Company cannot be billed for my negligence.

I understand and agree that when I need to cancel an appointment, I will call the office and either inform them directly or leave a message **at least twenty-four hours prior** to the scheduled appointment.

If I should fail to cancel twenty-four hours or more prior to the scheduled appointment, I agree to be billed at the contracted rate of up to $**150.00** for a missed appointment.

_____
Patient Signature

_____
Supervisor or Therapist

_____
Date

ADULT SYMPTOM RATING SCALE

Please rate the highest severity of each symptom listed below during the ***past two months*** by putting an X in the appropriate box to the right as follows: **0=None 1=Mild 2=Moderate 3=Severe 4=Profound**

Symptom Description	0	1	2	3	4
1. DEPRESSED/SAD MOOD					
2. LOSS OF INTEREST OR PLEASURE IN THE USUAL THINGS					
3. APPETITE CHANGE - INCREASE OR DECREASE					
4. WEIGHT GAIN OR LOSS					
5. PROBLEMS FALLING OR STAYING ASLEEP					
6. SLEEPING TOO MUCH					
7. FATIGUE, NO ENERGY					
8. FEELINGS OF GUILT OR WORTHLESSNESS					
9. CONCENTRATION PROBLEMS					
10. THOUGHTS OF DEATH WITHOUT INTENT TO SUICIDE					
11. CRYING SPELLS					
12. SEXUAL PROBLEMS					
13. LACK OF FEELINGS					
14. NIGHTMARES, FLASHBACKS, REPEATED THOUGHTS OF PAST UPSETTING TRAUMAS					
15. INTENSE REACTION TO SOME REMINDERS OF PAST TRAUMA					
16. TRYING TO AVOID THINKING OF PAST TRAUMA(S) OR OTHER REMINDERS OF THEM					
17. NERVOUS, ON GUARD					
18. ANXIETY, WORRY					
19. IRRITABILITY, ANGER					
20. EXCESS DIETING, VOMITING					
21. OFTEN MISS WORK					
22. DRINKING PROBLEM					
23. DRUG USE PROBLEM					
24. SUBSTANCE ABUSE					
25. HOME LIFE PROBLEMS					
26. SOCIAL LIFE PROBLEMS					
27. PROBLEMS WITH CHILD					
28. WORK PROBLEM					
29. INTENSE DISCOMFORT OR FEARS PEAKING IN 10 MINUTES					
30. UNEXPECTED SPELLS OR ATTACKS					
31. FEAR OF LEAVING HOME, CROWDS, PLACES YOU CAN'T LEAVE					
32. FEAR OF HUMILIATION CAUSES FEAR OF BEING WATCHED OR SEEN AND SOCIAL PROBLEMS					
33. EXCESS WORRY ABOUT TWO OR MORE DIFFERENT ISSUES					
34. EXCESS WORRY FOR 6 MONTHS					
35. MUSCLE TENSION					
36. REPETITIVE ACTS LIKE COUNTING, CHECKING, WASHING					
37. DISTRESSING THOUGHTS YOU CAN'T GET RID OF					
38. OTHER FEARS AND PHOBIAS					

Patient Name_____ TP #1

ADULT SYMPTOM RATING SCALE

Please continue rating the severity of symptoms within the *past two months*: 0=None 1=Mild 2=Moderate 3=Severe 4=Profound

Symptom Description	0	1	2	3	4
39. TROUBLE FINISHING PROJECTS, ATTENTION DRIFTING					
40. PROBLEMS ORGANIZING TASKS					
41. FORGETTING APPOINTMENTS, ETC.					
42. FRUSTRATED CAREER GOALS					
43. OTHER MEMORY PROBLEMS					
44. CONFUSION					
45. BELIEFS THAT SEEM STRANGE TO MOST OTHERS					
46. CHRONIC PAIN					
47. HEADACHES					
48. STOMACH PROBLEMS					
49. HEART PALPITATIONS					
50. SHORTNESS OF BREATH					
51. NUMBNESS OR TINGLING					
52. DIZZINESS					
53. BODY WEAKNESS					
54. BLACKOUTS					

55. WIDE DAILY MOOD SWINGS					
56. NEEDED LESS SLEEP, YET NOT TIRED FOR DAYS					
57. HIGH ENERGY FOR DAYS					
58. EXTRA TALKATIVE FOR DAYS					
59. RACING THOUGHTS FOR DAYS					
60. COMPULSIVE SPENDING					
61. HEARING VOICES WHEN NO ONE IS THERE					
62. SEEING THINGS THAT ARE NOT THERE					
63. THOUGHTS OF HOMICIDE					
64. THOUGHTS OF SUICIDE					
65. SUICIDAL ATTEMPT(S)					

Please describe the symptoms that most concern you _____

_____

Patient Signature _____Date_____ Therapist Signature _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

THIS AUTHORIZATION TO RELEASE, REQUEST OR DISCLOSE INFORMATION IS TO COMPLY WITH THE TERMS OF THE CONFIDENTIALITY OF MEDICAL INFORMATION ACT 1981, SECTION 56 ET SEQ., OF THE CALIFORNIA CIVIL CODE.

_____ _____/_____/_____
Patient Name Date of Birth

_____
Address City State Zip

For coordination of care, I hereby authorize the release of information:

TO AND FROM TO FROM _____

A Better Day
7525 Maude Adams Avenue
29 Palms, CA 92277

And my (the patient's) **physician**: Doctor's Name: _____

Address: _____ Phone: _____

Limits on information disclosure: None Limit to _____

-OR-

At this time I do NOT wish to have any information released to my physician.

I understand that I can receive a copy of this authorization upon my request. This authorization may be removed in writing at any time by the undersigned, and if not earlier revoked, shall terminate on:

_____.
Date or terms

_____ _____
Signature of Patient Date

_____ _____
Signature of Therapist Date

AUTHORIZATION TO BILL INSURANCE

Patient Name: _____ DOB: ____/____/_____

I hereby authorize the release of information:

TO AND FROM
A Better Day
7525 Maude Adams Avenue
29 Palms, Ca 92277

AND

Health Insurance Company: _____

Please read the following declaration then sign and date below where indicated.

I request that payment of authorized medical services furnished to me or my minor child be made by my insurance company, on mine or my minor child's behalf, to the provider of service indicated above. I authorize the medical provider listed above and his agents to release any information concerning my medical care to my insurance company and any of its agents for the sole purpose of determining benefits payable on my medical related charges.

I understand my signature on this form authorizes my insurance company to make payment directly to the provider referenced above and that I am authorizing my provider to release all medical information necessary to adjudicate my medical claims. The patient is responsible for deductibles, coinsurance, in any non-covered services. This policy applies to secondary and subsequent plans as well.

_____ _____
Signature of Patient (Parent/Guardian/Conservator) Date

INITIAL ASSESSMENT QUESTIONNAIRE

Briefly describe why you are seeking treatment t day. Please include the Psychological and Social factors and provide a brief history.

_____
_____
_____
_____
_____
_____
_____
_____

What single *specific event* made you seek consultation *today* as opposed to an earlier time?

_____
_____
_____
_____
_____
_____

How long has the chief complaint been present?

_____

What are your medical concerns? Explain below or check None _____

_____
_____

Any Special Status Issues? Court Mandated Criminal Family Court Work Related Disability None

What are the expectations for treatment outcome?

_____
_____

Household Members

Names	Age	Relationship
1._____		
2._____		
3._____		
4._____		
5._____		
6._____		
7._____		
8._____		

MEDICAL AND BEHAVIORAL HEALTH HISTORY

Behavioral Health History:

Has patient been in counseling before? Yes No
When? Where? How Long? With Whom? Successful? Why Stopped?

_____
_____
_____
_____

For what was the patient being treated? Diagnosis?
Do you want the Therapist to get records? Yes No

_____
_____
_____

Has patient been hospitalized for a mental health illness? Yes No
When? Where? How Long?

_____
_____
_____

Is there a history of suicidal thoughts or attempts? Yes No
Please Explain.

_____
_____
_____

Any history of self-injury? Yes No

_____
_____
_____
_____

Is there a family history of suicide or homicide? Yes No

_____
_____
_____

Have any close relatives used medication for mental health? Yes No

Please mark below any family members who have suffered with mental illness or alcoholism.

Biological Father		Biological Mother	
Brothers		Sisters	
Paternal Grandparents		Maternal Grandparents	
Paternal Aunts & Uncles		Maternal Aunts & Uncles	
Paternal Cousins		Maternal Cousins	
		None	

Has patient been hospitalized for alcohol or drug abuse/dependency? Yes No
If yes, please explain. _____

Has patient used: AA NA Other community resources (please list below) None

_____

Does patient use alcohol? Yes No How often? How long?

Does patient smoke? Yes No How often? How long?

Does patient use caffeine? Yes No How often? How long?

_____
_____
_____

Has patient ever had medication prescribed for mental health reasons? Yes No

Please describe any allergies or bad side effects from previously prescribed medications: or None

_____
_____
_____
_____

Does patient have allergies? Yes No Please describe below:

_____
_____
_____

PLEASE LIST ALL CURRENT MEDICATIONS:

Medications	Amount	How Often	Reason
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Prescribing Physician's Name Address Phone #

_____
_____
_____

Do you want to sign Release Of Information to the M.D.? Yes No

Medical History:

Are there current medical problems? Yes No

If yes, please explain. What effect does your medical condition have on your mental health?

_____

_____

Please check box if you have had or are experiencing any of the following conditions:

- ☐ **Cardiovascular disease**
- ☐ **Hormone *disorder***
- ☐ **Concussion or head *Heart disease***
- ☐ **Diabetes**
- ☐ **Seizures *Chest pain or angina***
- ☐ **Colder than *Swelling of hands, feet or***
- ☐ **Hypertension**
- ☐ **Skin is becoming Stroke(s)**
- ☐ **Thyroid dysfunction Gastrointestinal disorder**
- ☐ **Frequent diarrhea**
- ☐ **Renal (kidney) Peptic ulcer**
- ☐ **Liver disease Endocrine Disorder**
- ☐ **Hepatitis Hormonal change**
- ☐ **Jaundice**
- ☐ **None**
- ☐ **Replacement**
- ☐ **Neurological ankles boils**
- ☐ **Concussion**
- ☐ ***before Rendered unconscious***
- ☐ ***Frequent infections or* injury**
- ☐ **dryer**
- ☐ **Blood disorders**
- ☐ **Malignancy**
- ☐ **Genitourinary problems**
- ☐ **Eye disorders disease**
- ☐ **Glaucoma**
- ☐ **Respiratory problems**
- ☐ **Asthma or wheezing**
- ☐ **of the above**

Please give details below to the above medical conditions to which you responded, "Yes".

_____

_____

_____

_____

_____

Has there been a recent medical check up, or lab work done? Yes No

If yes, When? _____

Do you want release of information signed for your medical history? Yes No

Please mark an "**X**" in the appropriate box for anyone in the family history who have had any of the following, whether formally diagnosed or not:

Key: B=brother; S=sister; F-father; GM=grandmother; GF=grandfather; U=uncle; A=aunt; C=cousin.

Family Behavior History				Father's Side of Family						Mother's Side of Family					
Condition	Self	B	S	F	GM	GF	U	A	C	M	GM	GF	U	A	C
Attention Deficit or Inattention															
Hyperactivity															
Oppositional Defiance															
Bipolar															
Depression															
Anxiety															
Social Avoidance															
Other: _____															

Social History

Is patient married or in a current relationship? Yes No
Is the relationship supportive or problematic? Please be specific:

_____
_____
_____
_____
_____

Is patient experiencing any current problems with family members? Yes No Please Explain:

_____
_____
_____
_____
_____

Patient's birth order among siblings _____

How was the patient raised?
Natural parents_____ Foster Parents_____ Adopted_____ Intact Family_____ Single Parent Home_____ Parents Separated _____ Divorced _____

Please describe the parental style of your parents. Include events which may be relevant.

_____
_____
_____
_____
_____
_____
_____

Please circle the major stressors in your life from the following:

Health Finances Housing Relationships Work Culture Religion Ethnicity

Education Age Related Concerns Other *(please explain below)*:

_____
_____
_____
_____
_____
_____
_____

Notes:

_____
_____
_____
_____
_____
_____
_____
_____

HIPPAA NOTICE OF PRIVACY PRACTICES

This Information is made available to all patients

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

THIS NOTICE APPLIES TO ALL THE RECORDS OF YOUR CARE GENERATED BY THE PRACTICE, WHETHER MADE BY THE PRACTICE OR AN ASSOCIATED FACILITY.

This notice describes our Practice's policies, which extend to:

- Any health care professional authorized to enter information into your chart (including all behavioral health care professionals, RNs, etc.);
- All areas of the Practice (front desk, administration, billing and collection, etc.
- All employees, staff and other personnel that work for or with our Practice; - Our business associates (including billing services).
- Behavioral health hospitals, and so on.

The Practice provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR THOUGHTS ABOUT YOUR PROTECTED HEALTH INFORMATION

We understand that your behavioral health/medical information is personal to you, and we are committed to protecting the information about you. As your behavioral health professional, we create paper and electronic professional records about your behavioral/physical health, our care for you, and the services and/or items we provide to you. We need this record to provide for your care and to comply with certain legal requirements.

We are required by law to make sure that the protected health information about you is kept private, provide you with a Notice of our Privacy Practices and your legal rights with respect to protected health information about you, and follow the conditions of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE BEHAVIORAL HEALTH/MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose protected health information that we have and share with others. Each category of uses or disclosure provides a general explanation and some examples of uses. Not every use or disclosure in a category is either listed or actually in place. The explanation is provided for your general information only.

1) Behavioral Health/Medical Treatment. We use previously given behavioral health/medical information about you to provide you with current or prospective behavioral health treatment or services. Different employees within the Practice also may share information about you including your record(s), prescriptions, and requests of lab work history, treatment, and diagnosis. We may also discuss your behavioral health information with you to recommend possible treatment options. We also may disclose information about you to people outside the Practice who may be involved in your behavioral/medical care after you leave the Practice; this may include your family members, friends, or other personal representatives, **but only if** authorized by you or by a legal mandate (a guardian or other person who has been named to handle your medical decisions, should you become incompetent).
2) Payment. We may use and disclose behavioral health/medical information about you for services and procedures so they may be billed and collected from you, an insurance company, or any other third party. For example, we may need to give your health care information, about treatment you received at the Practice, to obtain payment or reimbursement for the care. We may also tell your health plan about treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

3.) Health Care Operations. Within our practice, we may us e and disclose behavioral health/medical Information about you so that we can run our Practice more efficiently and make sure that all of our patients receive quality care. These us es may include reviewing our treatment and services to evaluate the performance of our staff, deciding what additional services to offer and where, deciding what services are not needed, and whether certain new treatments are effective. F or both of the following, we will remove information that identifies you from the set of information so others may use it to study health care and health care delivery without learning who the specific patients are. In this non-identifying way, we may also disclose information to doctors, nurses, technicians, mental health/medical students, and other personnel for review and learning purposes.

4) Disclosure. We may also use or disclose information about you for internal or external utilization review and/or quality assurance to auditors to verify our records, to billing companies to aid us in this process and the like. We shall endeavor, at all times when business associates are used, to advise them of their continued obligation to maintain the privacy of your behavioral health/medical records. We expect then to keep your information in strict confidence.
5) Appointment and Patient Reminders. We may ask that you sign in writing at the Receptionist's Desk or waiting area, a "Sign In" log on the day of your appointment with the Practice. We may use and disclose behavioral health/medical information to contact you as a reminder that you have an appointment for medical care with the practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, e-mail, or otherwise and may involve the leaving of an e -mail, a message on an answering machine, or otherwise which could (potentially) be received or intercepted by others. You have the right, detailed on the next page, to let us know if you prefer some specific form of this communication.
6) Emergency Situations. In addition, we may disclose behavioral health/medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status and location.

Other Uses of Behavioral Health/Medical Information

Other uses and disclosures of behavioral Health/Medical information not covered by this notice or the laws that apply to us will be made only with your written permission, unless those uses can be very reasonably inferred from the intended uses above. If you have provided us with your permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke our permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Patient Rights

THIS SECTION DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THIS PRACTICE REGARDING THE USE AND DISCLOSURE OF YOUR BEHAVIORAL HEALTH/MEDICAL INFORMATION.

You have the following rights regarding Behavioral Health/Medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy behavioral health/medical information that may be used to make decisions about your care. This includes your own billing records, **but does not include psychotherapy notes.** Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

To inspect and copy your behavioral health/medical record, you must submit your request in writing to our Compliance Officer. Ask the front desk person for the name of the Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies (tapes, disks, etc.) associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to behavioral/medical information, you may request that our Compliance Committee review the denial. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome and recommendations from that review.

Right t o A mend. If you feel that the behavioral health/medical information we have about you (not **including psychotherapy notes**), in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the Practice maintains your record.

To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the behavioral health/medical information kept by or for the Practice; -
  Is not part of the information which you would be permitted to inspect and copy; or
- Is inaccurate and incomplete.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures. This is a list of the disclosures we may have made of behavioral health/medical information about you to others. To request this list, you must submit your request in writing. Your request must state a time period no longer than six (6) years bac k and may not include dates before April 1 4, 2003 (or the actual implementation date of the HIPAA Privacy Regulations). Your request should indicate in what form you want the list (for example, on paper, electronically). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. In general, your information will not be released to anyone except as outlined in this document. However, you have the right to request a restriction or l imitation on the behavioral/medical information we us e or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the behavioral health/medical information we disclose ab out you to someone who i s involved in your care or the payment f or your c are (a family member or friend). For example, you could ask that we not use or disclose information about a particular treatment you received.

We may not be able to comply with your request, if the information is exempted from the consent requirement or we are otherwise required to disclose the information by law.

To request restrictions, you must make your request in writing. In your request, you indicate: -
what information you want to limit;

- whether you want to limit our use, disclosure or both; and
- to whom you want the limits to apply, (e.g., disclosure to your parents, spouse, etc.)

Right to Request Confidential Communications. You have the right to request that we communicate with you about behavioral health/medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail or e-mail, or the like. To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish us to contact you.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes regarding medications, if you are taking any, efficiency of treatment protocols and the like. All research projects are subject to an approval process, which evaluates a proposed research project and its use of behavioral health/medical information. Before we use or disclose information for research, the project will have been approved through the research approval process. We will obtain a written Authorization from you before using or disclosing your individually identifiable health information. Otherwise, we will make the information non-identifiable to a specific patient. If the information has been sufficiently de-identified, an authorization for the use or disclosure in not required.

Required by Law. We will disclose behavioral health/medical information about you when required to do so by federal, state, or local law. Psychotherapy notes are especially guarded, and are considered confidential in most cases.

To Avert a Serious Threat to Health or Safety. We may use and disclose behavioral health/medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Workers' Compensation. We may release behavioral health/medical information about you for workers' compensation or similar programs, if you are claiming a behavioral health injury and we are ordered to do so by legal authority. Workers' compensation programs provide benefits for work-related injuries or illness.

Public health Risks. Law or public policy may require us to disclose behavioral health/medical information about you for public health activities. These activities generally include the need to report births and deaths; or to notify the appropriate government authority if we believe a child, elder, or dependent adult has been the victim of abuse or neglect. We will only make this disclosure if you agree or when required or authorized by law.

Investigation and Government Activities. We may disclose behavioral health/medical information t o a local, state or federal agency for activities authorized by laws. These oversight activities include, for example, audits, investigation, inspections, and licensure. These activities are necessary for the payor, the government and other regulatory agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or legal dispute, we m ay disclose medial information about you in response to a judge's order. This is particularly true if you make your behavioral health an issue in the case. Otherwise, judges do not or der the violation of the confidentiality of behavioral health records lightly. They only do so if they consider the information critical for a highly important matter. We may also use your information to defend ourselves or any member of our Practice in any actual or threatened legal action.

Law Enforcement. We may release behavioral health/medical information i f asked to do so b y a l aw enforcement official under the following circumstances:

- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Practice; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release behavioral Health/Medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death h. We may also release behavioral health/medical information about patients of the practice to funeral directors as necessary to carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a l aw enforcement official, we may release behavioral/medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for behavioral health/medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the Practice. The notice will contain on the first page, in the top right-hand corner, the date of last revision and effective date. In addition, each time you visit the Practice for treatment or health care services you may request a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact or office manager, who will direct you on how to file an office complaint. All complaints must be submitted in writing, and all complaints shall be investigated, without repercussion to you.

You will not be penalized for filing a complaint.

Acceptance of HIPAA Notice of Privacy Practices

Our full privacy policy is available for your review in the waiting area and on our website at www.affiliatedps.com
You may also request a copy from the front desk to take home with you. It contains important information about how your confidential health information will be handled by our offices.

I certify that I have been provided access to a copy of the HIPAA Notice of Privacy Practices.

_____ _____

Patient Signature Date

_____

Patient Printed Name

A Better Day

Advanced Directive

Any questions regarding this form please ask your practitioner

If a member is unable to make treatment decisions on his/her own because of physical or mental limitations, an Advanced Directive may be completed to allow a member's representative to make care or treatment decisions for the member.

Does this member already have an Advanced Directive? Yes No

If No, he/she does not have an Advanced Directive, the member should be directed to the website

https://www.courts.ca.gov/documents/Advanced-HealthCare-Directive-Form_031620.pdf or to

their health plan to obtain information about Advanced Directives.

If you would like to request of a copy of an Advanced Directive we will provide you with a sample form.

Member's Name: _____

Member's Signature: _____ Date: _____