Grace Counseling of Athens, LLC
Deborah C. Miller, MSN, APRN, PMHCNS-BC / Ashley House, MA, APC
1020 Barber Creek Drive, Suite 203. Watkinsville, GA 30677. 706-705-7005

MINOR CLIENT INFORMATION FORM

This Form is Confidential

Your child's name: _____ Today's date: _____

Parent or Legal Guardian's Name: _____

Name and relationship of person completing form: _____

Child's date of birth: _____ Gender: _____ Race/Ethnicity:_____

Home street address: _____

City: _____ State: _____ Zip: _____

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

Any calls will be discreet, but please indicate if any restrictions: _____

Parent or Legal Guardian Employed by: _____

Referred by: _____
May your therapist thank this person for the referral? Yes or No;
If referred by another clinician, would you like for your therapist to communicate with the clinician? Yes or No
In case of an emergency, please notify: _____Phone _____
We will only contact this person if we believe it is a life or death emergency.

CUSTODY/GUARDIANHIP
For clients who are minors in the care of a guardian other than a parent or whose parents are divorced or separated, a copy of the court custody/guardianship papers is required in order to receive services.

Describe special custody/guardianship arrangement: _____

If the child's/teen's parents are separated or divorced, describe the custodial agreement including who is responsible for health care decision making, visitation schedule and whether joint or sole custody:
_____
_____

CURRENT CONCERN(S)/REASON(S) SEEKING HELP
Briefly describe the current problem(s) and concern(s) for which help is being sought at this time:
_____
_____
_____
What are two or three goals you have for counseling/therapy?
_____
_____
What are two or three goals your child/teen has for counseling/therapy?
_____
_____

CLIENT MENTAL HEALTH HISTORY

List any psychiatrist, psychologist, or other mental health professional(s) who currently or previously has/have worked with your child/teen. Include approximate dates and reasons:_____

_____

Has your child/teen ever been diagnosed with *ADHD, Depression, Anxiety Disorder, OCD, Eating Disorder, Bipolar Disorder, Schizophrenia, behavior disorder, addiction problem or other mental health condition*? YES or NO, If yes, describe:_____

Has your child/teen ever threatened or attempted suicide or homicide? YES or NO, If yes, explain:_____

_____

_____

Does your child/teen currently struggle with thoughts of suicde, self harm or harm to other(s)? YES or NO, If yes describe:_____

Has your child/teen ever been hospitalized in a psychiatric hospital or facility? YES or NO, If yes, list approximate dates and circumstances:_____

Has your child/teen ever had treatment for a substance abuse problem or addiction problem(s)? YES or NO, If yes, describe type, treatment type and where treatment was received: _____

CLIENT DEVELOPMENTAL HISTORY

Was the child/teen full term at birth? YES or NO Type of Birth Delivery:_____

Explain any complications during pregnancy/birth: _____

_____

Was the child/teen exposed to any substances, toxins or stressors during pregnancy? YES or NO, If yes, explain.

_____

Describe type(s) of discipline used and whether effective or ineffective: _____

_____

Does child/teen currently have or ever had any difficulty with developmental milestones such as walking, talking, writing or any difficulty performing self-care skills such as toileting, bathing, dressing, etc.?

YES or NO, If yes, describe: _____

Has the child/teen ever received services such as Speech Therapy, Occupational Therapy, Physical Therapy or Babies Can't Wait? YES of NO, if yes describe services and where receives: _____

Any history of abuse? YES or NO, if yes, describe whether emotional, verbal, neglect, physical and/or sexual abuse:

_____

Any history of traumatic experiences or events? YES or NO, If yes, describe briefly: _____

_____

Within the last 6 months, has child/teen experienced any significant stressors such as the death of a close family member, friend or pet, divorce or separation of parents, school change or moved to a different home, etc.? YES or NO, If yes, describe: _____

_____

_____

CLIENT MEDICAL HISTORY

List significant medical problems, symptoms, surgery(ies), injuries or illnesses your child/teen *currently* has or has had in the *past*, the type of treatment and the name of treating provider(s):_____

_____

_____

Has the child/teen ever been hospitalized overnight? YES or NO, If yes, describe child's age, length of time and reason:

_____

List all prescriptions, doses, frequency and any natural supplements and over the counter medicines that your child takes on a regular basis:_____

_____

For females, age of menses _____. Describe cycles: regular, painful, etc.?_____

Primary Care Doctor/Provider_____ Phone_____ Date of Last Physical Exam _____

List any known allergies: _____

CLIENT ACADEMIC/SOCIAL HISTORY

Name of School:_____Current Grade Level: _____ Repeated Grades: _____

What is/are the child's/teen's academic strength(s)?_____

List any concerns related to the child's/teen's grades or academics: _____

Has the child/teen ever had educational testing? YES or NO. *If yes, please provide a copy of testing results if available.*

Any history of learning problems or disability? YES or NO, If yes, describe*:* _____

List child's/teen's personal strengths: _____

List child's/teen's hobbies/interests: _____

Describe child's/teen's social relationships with friends/peers: _____

List any concerns related to social groups/friends/peers:_____

Has the child/teen ever been suspended from school? YES or NO, If yes, describe: _____

Has the child/teen ever attended alternative school? YES or NO, If yes, describe: _____

Any known or suspected Alcohol or other substance use? YES or NO, If yes, list type, amount and frequency:_____

_____

CLIENT LEGAL HISTORY

Has the child/teen ever had any legal charges filed against him/her? YES or NO, If yes, describe:_____

_____

Is the child/teen currently on or ever been on probation? YES or NO, If yes, describe circumstances and probation length: _____

Has the child/teen ever been to a youth detention center? YES or NO, If yes, describe circumstances surrounding placement: _____

FAMILY RELATIONSHIP HISTORY

List the names, ages and relationships of all family members and others who live in the child's/teen's home:

_____

_____

_____

What is the child's/teen's parents' relationship to one another? *e.g. married, divorced, separated, never together, remarried, good, strained, etc.*:_____

Briefly describe quality of client's relationships with:

Mother _____ Father_____

Step parent(s) _____ Siblings _____

Grandparent(s):_____ Other _____

Has the child/teen ever been placed in foster care or in the care of anyone other than his/her parents during his/her lifetime? YES or NO, If yes, describe circumstances: _____

_____

Is client adopted? YES or NO, If Yes, describe child's/teen's knowledge and attitude about adoption?

_____

FAMILY MENTAL HEALTH HISTORY AND FAMILY LEGAL HISTORY

List any family history of substance abuse problems: If yes, describe relationship to the child/teen and type of substance:

_____

List any family members/close relatives with history of *Depression, Anxiety, Bipolar, Manic/Depression, Schizophrenia, OCD, suicide, homicide, addiction problems, Personality Disorder, ADHD and/or learning difficulties*: If yes, describe relationship to the child/teen and problem(s):_____

_____

List any family member(s)/close relative(s) with a history of psychiatric hospitalization and/or incarceration and reason(s) for either: _____

CULTURAL AND SPIRITUAL HISTORY

Is the child/teen experiencing any distress related to cultural differences, beliefs or values? YES or NO, If yes, describe:

_____

Does your child/teen attend a church or synagogue or other place of worship on a regular basis? YES or NO, If yes, name of place of worship and frequency:_____

How does prayer and/or Bible reading and/or other religious practices play a part in your child/teen's daily life? _____

_____

When the child/teen has/have religious/spiritual concern(s) who does he/she talk to? _____

Does the child/teen have a specific cultural or spiritual concern that is causing any known distress at this time?

_____

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD & CIRCLE THE MAIN PROBLEMS:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety			Tantrums			Nausea/Vomiting		
Depression			Parents Divorced			Stomach Aches		
Mood Changes			Seizures			Fainting		
Anger or Temper			Cries Easily			Dizziness		
Panic			Problems with Friend(s)			Diarrhea		
Fears			Problems in School			Shortness of Breath		
Irritability			Fear of Strangers			Chest Pain		
Concentration			Fighting with Siblings			Lump in Throat		
Headaches			Issues re: Divorce			Sweating		
Loss of Memory			Sexually Acting Out			Hears/Sees Things Not There		
Excessive Worry			History of Child Abuse			Muscle Tension		
Wetting the Bed			History of Sexual Abuse			Bruises Easily		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Separation Anxiety			Hurting Self			Fidgets Frequently		
Alcohol/Drugs			Thoughts of Suicide			Impulsive		
Drinks Caffeine			Sleeping Too Much			Waiting His/Her Turn		
Head Injury History			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Head Injury			Sleeping Alone			Chills or Hot Flashes		

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INFORMATION, AUTHORIZATION & CONSENT TO TREATMENT

Welcome to Grace Counseling of Athens, LLC. This document is designed to inform you about what you may expect as well as policies regarding confidentiality, privacy, etc. Therapists are responsible for practice in accordance with Georgia legal codes and the code of ethics pertaining to each's perspective profession. A description of the provider's background, education, practice and theoretical perspective is available on the web at www.gracecounselingathens.com. If applicable, your therapist will inform you in writing of any required supervision of her practice and ask you to sign written consent in accordance with agreement of such.

At Grace Counseling of Athens, LLC we believe that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with your therapist at any point.

In order for therapy to be most successful, it is important for the client to take an active role. This means working on the things you and your therapist talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is our policy to only see clients who we believe have the capacity to resolve their own problems with our assistance. It is our intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without your therapist. We also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, your therapist will direct you to other resources that will be of assistance to you. Your personal development is our number one priority. We encourage you to let us know if you feel that transferring to another facility or another therapist is necessary at any time. Our goal is to facilitate healing and growth, and we are very committed to helping you in whatever way seems to produce maximum benefit. If at any point you are unable to keep your appointments or we don't hear from you for one month, we will need to close your chart. However, reopening your chart and resuming treatment is always an option.

Confidentiality and Records

Your communications with your therapist will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your therapist will always keep everything you say to her confidential, with the following exceptions: (1) you direct your therapist to tell someone else and you sign a "Release of Information" form; (2) your therapist determines that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) your therapist is ordered by a judge to disclose information. In the latter case, your therapist's license does provide her with the ability to uphold what is legally termed "privileged communication". Privileged communication is your right as a client to have a confidential relationship with a counselor.

Please initial that you have read this page _____

Financial Responsibility

Each provider sets her own fees and uses a sliding fee scale based off of family size and income. Payment is due at the time services are rendered. Cash and personal checks are acceptable forms of payment and will be collected at either the beginning or conclusion of each session. Please note that there is a $20 fee for any returned checks. Any fees resulting from a returned check must be paid in full before the next session with your therapist. First time evaluation sessions are 1 hour in length and are $130. Follow up 50-minute therapy sessions range from $65 to $100 depending on the provider. You or your child(s) regular session fee will be determined at the initial visit once the sliding fee scale form is completed. For longer sessions and/or group/family sessions, fees will differ. From time to time at your request, your therapist may write a letter on your behalf. Your therapist will notify you of the fee in advance which will be determined based on the length of time/preparation required.

Please be aware your therapist does not file insurance claims for clients but will be happy to provide you with the necessary paperwork if you plan on filing for covered out of network benefits. If so, you will need to inform your therapist, and a superbill will be provided to you that includes a CPT procedural psychotherapy code and an ICD10 diagnosis code which often maybe a psychiatric diagnosis code. Some clients do not wish for their insurance companies to have such information. Therefore, it is your decision whether you would like to provide the superbill information to your insurance provider or not. It is important to be aware that insurance plans may vary regarding which diagnosis code, procedure code and type of provider that they cover. Each therapist records codes consistent with the services rendered and the treating problem. Insurance companies have many rules and requirements specific to each plan, and it is your responsibility to know your insurance company's policies and benefits. Your therapist is unable to accept any request(s) by a client/guardian to change a code for billing purposes. Any dispute(s) or disagreement(s) about your insurance company's coverage/benefits/reimbursement remains between you and your insurance company, and ultimately it is your financial responsibility to provide payment for services received at the agreed upon sliding fee rate.

Needing to talk to your therapist between sessions may indicate that you need extra support. If this is the case, you and your therapist will need to explore adding sessions or developing other resources available to help you. Telephone calls that exceed 10 minutes in duration will be billed at $2 per minute.

All fees are due prior to the next scheduled session unless a payment arrangement has been made.

Cancellation Policy

In the event that you are unable to keep an appointment, you must notify your therapist at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

In Case of Emergency

As your therapist's office is not an emergency receiving center, in the event of a mental health emergency or life-threatening situation, please do not wait for a call back, but do one or more of the following: • Call 911 • Go to the nearest emergency room • Call Behavioral Health Link/GCAL: 800-715-4225 • Contact The National Suicide Prevention Hotline: 800-273-TALK (8255) • Contact the Crisis Text Line – 741741. All of these resources are available 24 hours per day, 7 days per week.

Contacting Your Therapist

Calls are answered by an automated attendant. Please leave a brief message should you need to schedule or reschedule an appointment. Calls are usually returned within 24 hours of the next business day, and your therapist will let you know of her usual office days/hours for returning calls. Your therapist values each client and the time set aside for each

client's session. That means that she has limited time availability and must limit any out-of-session communication. When information needs to be shared outside of regularly scheduled appointments, your therapist offers clients and/or parents/guardians the option of setting up an additional appointment. Please notify your therapist by phone call of any major change with you or your child/teen between sessions. For life threatening emergencies or changes first do as instructed above.

Other Client Responsibilities

Clients are expected to participate in the planning of their treatment, and they or their guardian(s) have the responsibility to provide accurate information relevant to treatment and/or treatment planning, and follow mutually agreed upon treatment goals. Failure to provide accurate and relevant information as well as follow mutually agreed upon treatment may result in dismissal. Clients have the responsibility to treat his/her therapist appropriately with consideration and respect.

Professional Relationship

Psychotherapy/counseling is a professional service your therapist will provide to you/your child/teen. Because of the nature of therapy, your relationship with your therapist has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. You should also know that therapists are required to keep the identity of their clients confidential. As much as your therapist would like to, for your confidentiality, she will not address you /your child/teen in public unless you/they speak to her first. Your therapist also must decline any invitation to attend gatherings with your family or friends. In sum, it is the duty of your therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

Child Custody Policy

For minors in the care of a guardian other than a parent, or whose parents are divorced or separated, in order to receive services, a copy of the court custody/guardianship papers is required.

Ethics/Client Welfare and Safety

Due to the very nature of counseling/psychotherapy, as much as your therapist would like to guarantee specific results regarding your therapeutic goals, she is unable to do so. However, your counselor/therapist, with your participation, will work to achieve the best possible results for you. Additionally, as sensitive topics are explored and discussed some clients may feel somewhat worse when they first begin therapy before they begin to feel better. For child/teen clients, behaviors may worsen before they get better as issues/problems are explored. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and your therapist are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is your therapist's intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Each therapist is committed to rendering services in a professional manner consistent with the ethical standards of her prospective profession as well as the Code of Ethics of the American Association of Christian Counselors. It is your therapist's desire to work with clients about any grievances that may arise and build upon the therapeutic relationship. Clients have the right to refuse treatment and discontinue at any time. However, it is believed best when done in consultation with the therapist. If at any time you feel your counselor/therapist is not performing in an ethical or professional manner, please let her know immediately. If the two of you are unable to resolve your concern, please

contact Deborah Miller at 706-705-7005, ext. 1. Clients have the right to file complaints with freedom from restraint, interference, coercion or reprisal.

Right to Non - Discrimination

Clients have the right to be treated with consideration, respect, and full recognition of dignity and individuality regardless of circumstances.

Biblical and Spiritual Practices in Counseling

Your therapist does not presume that all clients want or will be receptive to explicit, spiritual Judeo-Christian interventions in counseling. Therefore, your therapist will honor client/parent/guardian consent, choice, receptivity to these practices, and the timing and manner whether these elements are introduced. This includes, but is not limited to the following: (1) prayer for and with clients; (2) Bible reading and reference; (3) spiritual meditation; (4) the use of biblical and religious imagery or music; (5) assistance with spiritual formation.

New Client Evaluation Process

For adult clients, the first appointment is for assessing and understanding the problems for which the client is seeking assistance. For minors, the evaluation process is a two-step process with initial separate appointments with the parent(s)/guardian(s) and the other with the child or teenager. These initial evaluation appointments are important to planning appropriate care and treatment. After the evaluation, should it be apparent that a higher level of care or treatment is needed beyond what the counselor/therapist is able to provide, other referral resources will be provided.

Technology Statement

In the ever-changing technological society, there are several ways your therapist could potentially communicate and/or follow each other electronically. It is of utmost importance to your therapist that your confidentiality is maintained, your boundaries respected, and to ascertain that your therapist relationship remains therapeutic and professional. Therefore, the following policies have been developed:

Cell phones and Landline telephones:

It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special technology. Individuals who have access to your telephone or your telephone bill may be able to determine who you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided your therapist with that phone number, your therapist may contact you on this line from a landline in this office or from a cell phone, typically only for purposes of setting up an appointment if needed. If this is not an acceptable way to contact you, please let your therapist know.

In addition to landlines, cell phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see who you have talked to, who initiated that call, how long the conversation was, and where each party was located when that call occurred. However, your therapist realizes that most people have and utilize a cell phone. Your therapist may also use a cell phone to contact you, when returning your call and typically only for purposes of setting up an appointment if needed. Additionally, your therapist may keep your phone number in his/her cell phone. His/her phone is password protected. If this is a problem, please let your therapist know, and you he/she will be glad to discuss other options.

Please initial that you have read this page _____

Text Messaging and Email:
Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. Your therapist realizes that many people prefer to text and/or email because it is a quick way to convey information. However, please know that it is your therapist's policy to utilize these means of communication strictly for appointment confirmations (nothing that could be inferred as therapy). Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. If you do, please know that your therapist will not respond. You also need to know that your therapist is required to keep a summary or a copy of all emails and texts as part of your clinical record that address anything related to therapy.

Facebook, LinkedIn, Instagram, Pinterest, Twitter, Etc.:
It is your therapist's policy not to accept requests from any current or former clients on social networking sites such as Facebook, LinkedIn, Instagram, Pinterest, etc. because it may compromise your confidentiality.

Google, Bing, etc.:
It is your therapist's policy not to search for clients on Google or any other search engine. Your therapist respects your privacy and makes it a policy to allow you to share information about yourself to your therapist as you feel appropriate. If there is content on the internet that you would like to share with your therapist for therapeutic reasons, please print this material and bring it to your session.

Faxing Medical Records:
If you authorize your therapist (in writing) via a "Release of Information" form to send your medical records or any form of protected health information to another entity for any reason, your therapist may need to fax that information to the authorized entity. It is your therapist's responsibility to let you know that fax machines may not be a secure form of transmitting information and will only send information via fax at your request/signature. Currently, this office does not have fax accessibility.

Recommendations to Websites or Applications (Apps):
During the course of treatment, your therapist may recommend that you visit certain websites for pertinent information or self-help. She may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites and/or apps, may be able to see you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide and communicate to your therapist if you would like this information as adjunct to your treatment or if you prefer your therapist does not make these recommendations. In summary, technology is constantly changing, and there are implications to all of the above that your therapist may not realize at this time. Please feel free to ask questions, and know your therapist is open to any feelings or thoughts you have about these and other modalities of communication.

Agreement to Enter into a Therapeutic Relationship

Your therapist is sincerely looking forward to facilitating you or your child/teen on your or his/her journey toward healing and growth. If you have any questions about any part of this document, please ask your therapist. Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with your therapist/group leader, and you are authorizing your therapist/group leader to begin treatment with you or with your child/teenager if authorizing for a minor. Your signature also indicates you

Please initial that you have read this page _____

have received the Health Insurance Portability and Accountability Act (HIPAA) information.

_____ If client is a minor: _____

Client Name (Please Print) Parent or Legal Guardian's Name (Please Print)

_____ _____

Client or Parent/Legal Guardian Signature Date

The signature of the therapist below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

_____ _____

Therapist's Signature Date

Latest revision: 02/01/20

Please initial that you have read this page _____

Health Insurance Portability and Accountability Act (HIPPA) Notice of Privacy Practices
Grace Counseling of Athens, LLC
Deborah C. Miller, APRN, PMHCNS-BC or Ashley House, MA, APC
1020 Barber Creek Drive, Suite 203, Watkinsville, GA 30677

I.COMMITTMENT TO YOUR PRIVACY*: Grace Counseling of Athens, LLC the independent practice of Deborah C. Miller and the other above listed independent contractor/practitioner* are each dedicated to maintaining the privacy of your protected health information (PHI). PHI is information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services either in paper or electronic format. This Notice of Privacy Practices ("Notice") is required by law to provide you with the legal duties and the privacy practices that *each therapist or her employee(s) or business associate(s)* maintain concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

II. LEGAL DUTY TO SAFEGUARD YOUR PHI: By federal and state law, *each therapist and her employee(s) or business associate(s)* are required to ensure that your PHI is kept private. This Notice explains when, why, and how *each therapist or her employee(s) or business associate(s)* would use and/or disclose your PHI. Use of PHI means when *a therapist or her employee(s) or business associate(s)* shares, applies, utilizes, examines, or analyzes information within her practice; PHI is disclosed when *a therapist or her employee(s) or business associate(s)* releases, transfers, gives, or otherwise reveals it to a third party outside of the therapist's practice. With some exceptions, *each therapist or her employee(s) or business associate(s)* may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, *each therapist or her employee(s) or business associate(s)* is always legally required to follow the privacy practices described in this Notice.

III. CHANGES TO THIS NOTICE: The terms of this notice apply to all records containing your PHI that are created or retained by *each therapist or her employee(s) or business associate(s)* Please note that *each therapist* reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that *each therapist* has created or maintained in the past and for any of your records that *each therapist* may create or maintain in the future. *Each therapist* will have a copy of the current Notice in the office in a visible location at all times, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of the Notice of Privacy Practices.

IV. HOW YOUR NAME MAY USE AND DISCLOSE YOUR PHI: *Each therapist or her employee(s) or business associate(s)* will not use or disclose your PHI without your written authorization, except as described in this Notice or as described in the "Information, Authorization and Consent to Treatment" document. Below you will find the different categories of possible uses and disclosures with some examples. 1. For Treatment: *Each therapist* may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are; otherwise involved in your care. Example: If you are also seeing a psychiatrist for medication management, *your therapist* may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, *each therapist* will always ask for your authorization in writing prior to any such consultation. 2. For Health Care Operations: *each therapist or her employee(s) or business associate(s)* may disclose your PHI to facilitate the efficient and correct operation of its practice, improve your care, and contact you when necessary. Example: Your therapist may use health information about you to manage your treatment and services. 3. To Obtain Payment for Treatment: *Each therapist or her employee(s) or business associate(s)* may use and disclose your PHI to bill and collect payment for the treatment and services *your*

therapist provided to you. Example: *Each therapist or her employee(s) or business associate(s)* may disclose your PHI to request payment for any unpaid health care services that have been provided to you. *Each therapist or her employee(s) or business associate(s)* could also provide your PHI to billing companies, claims processing companies, and others that collect/process health care claims for *your therapist's* office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, *your therapist* will always do her best to reconcile this with you first prior to involving any outside agency. 4. Employees and Business Associates: There may be instances where services are provided to *each therapist* by an employee or through contracts with third-party "business associates." Whenever an employee or business associate arrangement involves the use or disclosures of your PHI, *your therapist* will have a written contract that requires the employee or business associate to maintain the same high standards of safeguarding your privacy that is required of *your therapist.* Note: This state and Federal law provides additional protection for certain types of health information, including alcohol or drug abuse, mental health and AIDS/HIV, and may limit whether and how *each therapist* may disclose information about you to others**.**

V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES – *Your therapist* may use and/or disclose your PHI without your consent or authorization for the following reasons: 1. Law Enforcement: Subject to certain conditions, may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: *Your therapist* may make a disclosure to the appropriate officials when a law requires *your therapist* to report information to government agencies, law enforcement personnel and/or in an administrative proceeding. 2. Lawsuits and Disputes: *Each therapist* may disclose information about you to respond to a court or administrative order or a search warrant. *Your therapist* may also disclose information if an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. *Each therapist* will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the information requested. 3. Public Health Risks: *Each therapist* may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition. 4. Food and Drug Administration (FDA): *Each therapist* may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement. 5. Serious Threat to Health or Safety: *Your therapist* may disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if *the therapist* determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, *your therapist* may provide PHI to law enforcement personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public. 6. Minors: If you are a minor (under 18 years of age), *your therapist* may be compelled to release certain types of information to your parents or guardian in accordance with applicable law. 7. Abuse and Neglect: *Your therapist* may disclose PHI if mandated by Georgia child, elder, or dependent adult abuse and neglect reporting laws. Example: If *your therapist* has a

reasonable suspicion of child abuse or neglect, *your therapist* will report this to the Georgia Department of Child and Family Services. 8. Coroners, Medical Examiners, and Funeral Directors: *Your therapist or her employee(s) or business associate(s)* may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death or other duties as authorized by law. *Each* may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties. 9. Communications with Family, Friends, or Others: *Your therapist or her employee(s) or business associate(s)* may release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related decisions for you), or any other person you identify, relevant to that person's involvement in your care or payment related to your care. In addition, *each therapist* may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition. 10. Military and Veterans: If you are a member of the armed forces, *your therapist or her employee(s) or business associate(s)* may release PHI about you as required by military command authorities. *Your therapist or her employee(s) or business associate(s)* may also release PHI about foreign military personnel to the appropriate military authority. 11. National Security, Protective Services for the President, and Intelligence Activities: *Your therapist or her employee(s) or business associate(s)* may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law. 12. Correctional Institutions: If you are or become an inmate of a correctional institution *your therapist or her employee(s) or business associate(s)* may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others 13. For Research Purposes: In certain limited circumstances, *each therapist or her employee(s) or business associate(s)* may use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified, directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information. 14. For Workers' Compensation Purposes: *Your therapist or her employee(s) or business associate(s)* may provide PHI in order to comply with Workers' Compensation or similar programs established by law. 15. Appointment Reminders: *Your therapist or her employee(s) or business associate(s)* is permitted to contact you, without your prior authorization, to provide appointment reminders/changes or information about alternative or other health related benefits and services that you may need or that may be of interest to you. 16. Health Oversight Activities: *Your therapist or her employee(s) or business associate(s)* may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess *your therapist or her employee(s) or business associate(s)*, compliance with HIPAA regulations. 17. If Disclosure is Otherwise Specifically Required by Law. 18. In the Following Cases, *your therapist or her employee(s) or business associate(s)* Will Never Share Your Information

Unless You Give Written Permission: Marketing purposes, sale of your information, most sharing of psychotherapy notes, and fundraising. If you are contacted for fundraising efforts, you can tell your therapist not to contact you again.

VI. OTHER USES AND DISCLOSURES REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION: In any other situation not covered by this notice, *your therapist* will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying *your therapist* in writing of your decision. You understand that your *therapist or her employee(s) or business associate(s)* is unable to take back any disclosures it has already made with your permission, *your therapist or her employee(s) or business associate(s)* will continue to comply with laws that require certain disclosures, and *your therapist* is required to retain records of the care that each have provided to you.

VII. RIGHTS YOU HAVE REGARDING YOUR PHI: 1. The Right to See and Get Copies of Your PHI either in paper or electronic format: In general, you have the right to see your PHI that is in *each therapist's* possession, or to get copies of it; however, you must request it in writing. If *your therapist or her employee(s) or business associate(s)* do not have your PHI, but knows who does, you will be advised how you can get it. You will receive a response within 30 days of receiving your written request. Under certain circumstances, *each therapist* may feel it must deny your request, but if it does, *each therapist* will give you, in writing, the reasons for the denial. *Each therapist* will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged a reasonable fee per page and the fees associated with supplies and postage. *Your therapist* may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance. 2. The Right to Request Limits on Uses and Disclosures of Your PHI: You have the right to ask that *your therapist* limit how it uses and discloses your PHI. While *your therapist* will consider your request, she is not legally bound to agree. If *your therapist* does agree to your request, she will put those limits in writing and abide by them except in emergency situations. If you pay for a service or health care item out-of-pocket in full, you can ask your therapist not to share that information for the purpose of payment or your therapist's operations with your health insurer. You do not have the right to limit the uses and disclosures that *each therapist* is legally required or permitted to make. 3. The Right to Choose How *your therapist,* Sends Your PHI to You: It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). *Each therapist* is obliged to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience. 4. The Right to Get a List of the Disclosures. You are entitled to a list of disclosures of your PHI that *your therapist* has made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, or to corrections or law enforcement personnel. The request must be in writing and state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003. *Your therapist* will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a description of the information disclosed, and the reason for the disclosure. Your *therapist* will provide the list to you at no cost, unless you make more than one request in the same year, in which case it will charge

you a reasonable sum based on a set fee for each additional request. 5. The Right to Choose Someone to Act for You: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action. 6. The Right to Amend Your PHI: If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that *your therapist* correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of *your therapist's* receipt of your request. *Your therapist* may deny your request, in writing, if she finds that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, (c) not part of its records, or (d) written by someone other than *your therapist*. Denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and *your therapist's* denial will be attached to any future disclosures of your PHI. If *your therapist* approves your request, it will make the change(s) to your PHI. Additionally, *your therapist* will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI. 6. The Right to Get This Notice by Email: You have the right to get this notice by email. You have the right to request a paper copy of it as well. 7. Submit all Written Requests: Submit to *your therapist*, at the address listed on top of page one of this document**.**

VIII. COMPLAINTS: If you are concerned your privacy rights may have been violated, or if you object to a decision *your therapist* made about access to your PHI, you are entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services Office of Civil Rights. *Your therapist* will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint. Please discuss any questions or concerns with your therapist. Your signature on the "Information, Authorization, and Consent to Treatment" (provided to you separately) indicates that you have read and understood this document.

IX. EACH THERAPIST'S RESPONSIBILITY*: Your therapist and her employee(s)/business associate(s)* is/are required by law to maintain the privacy and security of your PHI. Your therapist will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. Your therapist must follow the duties and privacy practices described in this notice and give you a copy of it. *Your therapist and her employee(s)/business associate(s)* will not use or share your information other than as described here unless you tell your *therapist* she can in writing. If you tell your *therapist,* she can, you may change your mind at any time. If you change your mind, you must notify your *therapist* in writing.

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