PRACTICAL LIFE COUNSELING

Please note the following:

All forms must be filled out in full and brought to the first session. Please bring your insurance card if you planning to use insurance.

Be prepared to pay your copay or fees for counseling at the beginning of the session. If you chose to use a credit card to pay your fees/copay during your first session there may be an administrative delay while I set up your account. If you wish to avoid this delay you are free to bring cash or a check to the first session to cover your fees. After the first session you are free to use Visa, Mastercard, cash or check to pay your fees.

My goal is for your counseling to be a productive and meaningful experience from the very first session. If you have any concerns or questions regarding the forms required to begin counseling, please let me know immediately so I can answer your questions.

If you are going to use your insurance, it is very important to completely fill out the *Regarding Your Insurance Benefits* form. You will need to call your insurance company in order to certain of your copay, to determine any unpaid deductible that remains, and to insure that there have not been any changes to your mental health coverage since you last used it. Please use the *Regarding Your Insurance Benefits* form to assist you with gathering this information.

Again, it is crucial that you fill out all forms in full and bring them and any necessary items (insurance card, etc.) to your first session so that we can focus on you and the challenges you are facing instead of administrative issues.

I look forward to meeting you and helping you achieve your goals.

Sincerely,

Tina Marie Rees, MA, LPC
Practical Life Counseling

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Tools for a whole life...

CLIENT INFORMATION FORM

Date: _____

SECTION 1: CLIENT (name of person to be seen by the therapist)

Name: _____ Email: _____

Mailing Address: _____ Cell Phone: _____

_____ May I leave a detailed voice mail for you? Y N

_____

Gender: M F Date of Birth: _____

Social Security #: _____

SECTION II: PERSONAL INFORMATION

FAMILY / MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

_____ number of children living at home with you, part-time or full-time

Names and ages of children or other residents living in your home other than yourself:

Name	Age	Relationship to You	Name	Age	Relationship to You

CURRENT CONCERNS, OR REASONS FOR COMING TO COUNSELING: _____

_____

_____

_____

_____

_____

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EMERGENCY INFORMATION: **REQUIRED**

In case of emergency, notify: Name: _____ Relationship to you: _____

Phone Number: _____ ☐ Home ☐ Cell

*****I will contact your emergency contact person in the event that you miss an appointment and do not contact me to reschedule; such an event indicates that you may be seriously ill or have harmed yourself and are in need of assistance.**

REFERRAL: How were you referred to me? ☐ Friend ☐ Insurance ☐ Internet ☐ Minister

Other: _____

SECTION III: FINANCIAL RESPONSIBILITY

Insurance Policy Holder (if other than client) OR Third Party responsible for payment (not client or insurance policy holder)

Name: _____

Address: _____

City / St / Zip: _____

Home Phone: _____ Cell: _____

Gender: M F Date of Birth: _____ SSN # _____

Client's relationship to this person: ☐ Self ☐ Spouse ☐ Child ☐ Other

SECTION IV: INSURANCE **if you plan to use insurance, you must complete section II above**

Insurance Co Name: _____

Name of Behavioral Health Carrier: _____

(if not the same as your general health insurance company)

Upon your request, I will bill your insurance company for you (you must pay any deductibles and/or copayments.) **If preauthorization for treatment is required or you are using EAP benefits, you must obtain authorization PRIOR to the first session.** Please know that verification of insurance benefits is not a guarantee of payment. Final determination is made upon receipt of claim and review of all documentation. **If you insurance company denies payment for any reason, you will then be responsible for the amount due.** By signing below, you authorize Practical Life Counseling to release any information required for processing claims and to receive benefits due under your policy for services rendered:

Client or responsible party must sign. Thank you.

Authorized Signature: _____ Date: _____

PRACTICAL LIFE COUNSELING

Symptom Checklist

Name: DOB:

Please check (V) the items below that apply; you may place an asterisk (*) by the most important ones. If it does not apply to you, please leave it blank.

Recurrent unpleasant thoughts		Temper outbursts	
Trouble remembering things		Frequent arguments	
Difficulty getting things done		Urges to beat or harm someone	
Do things very slowly to ensure correctness		Urges to break things	
Mind going blank		Shouting or throwing things	
Double-check what you do		Afraid of open spaces	
Difficulty making decisions		Afraid to leave house alone	
Repeat behavior, like touching or washing		Avoid things, places or activities because they frighten you	
Feel criticized by others		Feel uneasy in crowds	
Uneasy with opposite sex		Feel others are to blame for most of your troubles	
Feelings easily hurt		Recurrent unpleasant memories	
Feel others do not understand you		Feel nervous when alone	
Feel people are unfriendly		Feel most people cannot be trusted	
Feel self-conscious with others		Feel you are being watched by others	
Feel inferior to others		Feel others will take advantage of you	
Feel low in energy		Feel others don't give you proper credit for achievements	
Thoughts of ending your life		Poor appetite	
Cry easily		Insomnia	
Feel trapped		Idea that someone or something else can control your thoughts	
Blame self for things		Hear voices	
Feel sad, blue		See shadows	
Worry too much		Hear knocking, footsteps, or other noises that others cannot hear	
Feel hopeless		Other people know your private thoughts	
Little interest in things		See people or objects that others cannot see	
Feel everything is hard		Feel lonely when with people	
Feel worthless		Thoughts about sex that bother you	
Nervous		Thoughts of death or dying	
Trembling		Never felt close to another person	
Fearful		Spells of panic	
Suddenly scared for no reason		Feeling that something bad is going to happen	
Racing heart		Feel easily annoyed	
Feel tense		Other:	
Feel restless			

7650 S. McClintock Road Suite 103-289, Tempe, AZ 85284 Tel: 602-341-8241 Fax: 815-346-8241

PRACTICAL LIFE COUNSELING

Comprehensive Medication List

Medication and Dosage	Why do you take this?	Frequency	Who prescribed this? Please circle one
____________________	____________________	____ times daily / weekly	Psychiatrist PCP Naturopath
____________________	____________________	____ times daily / weekly	Psychiatrist PCP Naturopath
____________________	____________________	____ times daily / weekly	Psychiatrist PCP Naturopath
____________________	____________________	____ times daily / weekly	Psychiatrist PCP Naturopath
____________________	____________________	____ times daily / weekly	Psychiatrist PCP Naturopath
____________________	____________________	____ times daily / weekly	Psychiatrist PCP Naturopath
____________________	____________________	____ times daily / weekly	Psychiatrist PCP Naturopath
____________________	____________________	____ times daily / weekly	Psychiatrist PCP Naturopath
____________________	____________________	____ times daily / weekly	Psychiatrist PCP Naturopath
____________________	____________________	____ times daily / weekly	Psychiatrist PCP Naturopath
____________________	____________________	____ times daily / weekly	Psychiatrist PCP Naturopath
____________________	____________________	____ times daily / weekly	Psychiatrist PCP Naturopath

7650 S. McClintock Road Suite 103-289 Tempe AZ 85284-1672 phone 602-341-8241 fax 815-346-8241

Consent for Treatment

PRACTICAL LIFE COUNSELING

I understand that I will be engaging in psychotherapy at Practical Life Counseling with Tina Marie Rees, LPC. The purpose of this treatment is so that I feel better or resolve specific life or adjustment problems that have caused me to seek assistance. The primary procedure used by Ms. Rees is "talk" therapy, although I understand that she may also provide general education about mental health conditions or coping strategies. She is a Certified EMDR practitioner and may use this technique with me. She may also assign "homework" for me to do in between sessions. The potential benefit of treatment is that I will feel better about my life. I understand that a "cure" is not guaranteed and that it is possible that as I talk about some things, I may even feel worse.

I understand that all information I share will be kept confidential, but that this confidentiality is not absolute. In the case of medical emergency, child/elder abuse or neglect, suicidal or homicidal intent, or under court order, clinical information may be released. I also understand that if my treatment is paid for by an insurance company, Ms. Rees will release clinical information to my insurer. Usually, only that information required for billing will be released, however, Ms. Rees must fulfill any and all requests for clinical information made by my insurance company.

I understand that as an independently licensed professional counselor in Arizona Ms. Rees is not obligated to receive clinical supervision. However, in an effort to provide services that reflect best practices, she belongs to a consultation group composed of other therapists that meets regularly and has also engaged a practice consultant with whom she discusses some clinical cases. I understand that if Ms. Rees discusses my case with the consultation group or with the practice consultant I will not be identified by name.

I understand that Ms. Rees will be texting me (or emailing me if I so request) to remind me of my scheduled appointment. I am not expected to respond to these appointment reminders. I also understand that Ms. Rees does not do counseling via email or text and will not respond to text messages or emails that deal with therapeutic issues. Ms. Rees and I will deal with therapeutic issues during counseling sessions and I am encouraged to maintain a journal or create a list of issues to bring with me to my counseling session to insure that my concerns are addressed in my counseling sessions.

I understand that I can receive a summary of treatment or a copy of my records or have a copy of my records provided to another person by completing a 'Release of Information' form. Ms. Rees retains the right to ask to meet with me prior to releasing any records or summary of treatment to anyone who is not a medical practitioner (i.e. my PCP, psychiatrist, or another counselor) in order to insure that I understand the implications of releasing my records to non-medical personnel. I understand that I will be required to pay for this session and that my insurance may not cover this session as it may not be therapeutic in nature.

I understand that I have the right to participate in treatment decisions and that Ms. Rees and I will together develop and periodically review and revise a treatment plan which will identify my goals for treatment as well as the means of achieving those goals. I understand that I have the right to refuse any recommended treatment and that I may withdraw my consent to treatment at any time with no consequences. I understand that if I do not attend a counseling session with Ms. Rees for a period of 45 consecutive days without making prior arrangements with Ms. Rees for this absence that the counseling relationship will be terminated; should this occur, I understand that I will be informed of the termination in a letter. I understand that I have the right to ask for a referral to another counselor should I require counseling that is outside of Ms. Rees's scope of practice or if I should decide to terminate counseling with Ms. Rees and seek treatment from another counselor. I also understand that Ms. Rees will immediately provide referrals to other counseling sources should she discover that my needs are outside of her scope of practice. I understand that it is my responsibility to attend sessions with another counselor should my needs be outside of Ms. Rees' scope of practice. If I refuse to seek another counselor despite Ms. Rees's recommendation that I do so, I realize that Ms. Rees has the right to refuse to treat any and all needs outside her scope of practice or to terminate our counseling relationship.

Consent for Treatment

understand that Ms. Rees will immediately provide referrals to other counseling sources should she discover that my needs are outside of her scope of practice. I understand that it is my responsibility to attend sessions with another counselor should my needs be outside of Ms. Rees' scope of practice. If I refuse to seek another counselor despite Ms. Rees's recommendation that I do so, I realize that Ms. Rees has the right to refuse to treat any and all needs outside her scope of practice or to terminate our counseling relationship.

Ms. Rees does not testify in court for clients at their request or at the request of their legal representative. Any and all requests for testimony must be made through the order of a judge requiring Ms. Rees to testify in court either on my behalf or on the behalf of the prosecution. If I wish for my clinical records or a summary of sessions to be released to my legal representative or to the prosecution, I must authorize this release on a *Release of Information* form specifically. I understand that I assume all legal liability for any authorized release of records. Ms. Rees cannot be held legally liable for any clinical records released by order of a judge.

I understand that I have the right and am encouraged to discuss any concerns or dissatisfaction I have with my experiences in counseling with Ms. Rees. I understand that any grievances I share with Ms. Rees will be addressed in session and Ms. Rees will do her best to resolve these grievances to my satisfaction. I understand that I have the right to terminate counseling and receive referrals to other counselors if these concerns cannot be resolved to my satisfaction.

I understand that the fees for counseling are $120 for a regular session and $180 for an intake session. I understand that if I do not have insurance, I have the right to ask for these fees to be adjusted to account for certain challenges in my life that are outside of my control. I understand that Ms. Rees is not required to adjust my fee and that any adjustment to my fee must be documented and signed by both parties.

If I will be using my insurance to pay for my counseling, I understand that Practical Life Counseling will bill my insurance company at the standard fee of $120 for a regular session and $180 for an intake session and will accept insurance payments as partial payment towards this fee. I will be responsible for paying all deductibles, as well as the agreed upon co-pay or co-insurance for each session covered by the insurance. Any excess insurance payments to Ms. Rees will be credited to my account and any insurance payments sent to me will be remitted to Ms. Rees up to the amount of my unpaid balance. Failure to do so will result in immediate charges to my credit card for the balance. I have been provided with and read the Policy for Secured Appointments. I understand that my insurance company is under contract with me and/or my employer and that I am ultimately responsible for all charges incurred for services at Practical Life Counseling.

My signature below signifies that I have received a copy of my HIPAA rights and the policy for secure storage of records. My signature below also signifies that any questions I may have had were answered to my satisfaction; that Ms. Rees has the right to bill my insurance company if I am using insurance; and that I have read the above information and consent for treatment.

Signature: _____ Date: _____

Guardian Signature (for minors only): _____ Date: _____

Witness: _____ Date: _____

PRACTICAL LIFE COUNSELING
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Financial Considerations

You are responsible for all costs related to your counseling. Fees for regular counseling sessions are $120 and intake sessions are $180. If you are unable to afford these fees and do not have insurance (hereafter called *private pay*) you are able to negotiate lower fees with Ms. Rees, with the goal of being able to financially afford to attend counseling sessions regularly. This fee reduction is called a **Social Justice Discount** and it must be agreed to in writing by both parties. Any charges for late cancellations or missed appointments will reflect the social justice discount agreement, if one has been signed and is still active.

All clients must secure future scheduled appointments by providing a valid and current credit or debit card at your first appointment. The card number and expiration date will be stored in the your file until you terminate the counseling relationship. The credit / debit card information will only be used in the event that you miss an appointment or cancel the appointment with less than 24 hours notice. **You will be charged $120 (or your negotiated private pay fee) for missed appointments and late cancellations.** Charges for late cancellations and missed appointments will be charged to the client's credit / debit card the day of their missed appointment/late cancellation. You are always free to use the credit card on file to pay for fees or copays.

At termination of the counseling relationship, your credit / debit card information will be destroyed. If you wish to reenter counseling after previous termination, you will need to supply current credit / debit information to secure appointments.

If you are using insurance: **If your insurance company denies payment for any reason that is within your control (does not reflect an error on my part) or if the amount charged is credited to your deductible, you will be responsible for the amount due from your insurance company.**

Receipts for automatic charges made to your credit / debit card will be made available to you at your request, either at the time of your next appointment or by mail when necessary.

Unpaid balances that cannot be collected through provisions for secured appointments and that remain unpaid for over sixty (60) days may be turned over to a collection agency.

Please read and sign below:

I agree to provide Practical Life Counseling with credit card / debit card information that is current and valid. I understand that charges for balances owed may be made to my credit / debit card at any time. If I have questions about these charges, I am entitled to a full explanation and proof of moneys owed; these will be provided by Practical Life Counseling and/or my insurance company. I understand that I will be charged the fee designated above for all missed appointments or late (less than 24 hour) cancellations of appointments.

Authorized Signature: _____ Date: _____

Credit Card Number: _____ (Mastercard or Visa only)

Expiration Date: _____ / _____ (mm/yyyy) CCV _____ (on back of card)

Rev 4/28/2020

Tina Marie Rees

PRACTICAL LIFE COUNSELING
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3200 N. Dobson Road
Bldg C Suite 108
Chandler AZ 85224
Phone: 602-341-8241
Fax: 815-346-8241

Authorization for Release of Information

Name of Client: _____ Date of Birth: _____

I hereby authorize _____ and Practical Life Counseling to exchange
(Name of Therapist)
Information about my mental and physical health with:

Name: _____
(Name of Individual, Physician, Practice, or Therapist)

Address _____

Phone : _____ Fax: _____

Information to be exchanged may include summary of treatment, diagnosis, attendance and dates of attendance, psychological evaluation / test results, and medical and/or mental health records. This information, if exchanged, will be use to coordinate and increase the quality of my care.

I understand that my clinical treatment records may be protected by federal regulations that may determine the extent and nature of the information that may be disclosed pursuant to this authorization. I do hereby give this consent to the release of the records described above freely and voluntarily, and acknowledge that I am not under and force or duress. I further understand that the provision of treatment and care will not be denied by reason of refusal to sign this consent form.

I understand that the policy of Practical Life Counseling is to release only that information about a client/former client, which, in judgment of Ms. Rees, is considered essential for the above purpose. The authorization does not obligate Practical Life Counseling to open its records for inspection, or to otherwise provide information which may violate the above policy.

Practical Life Counseling is hereby released from any and all legal liability that may arise from the discloser of the information requested. If no specific date, event, or condition is indicated, this consent will last no longer than reasonably necessary to serve the purpose for which it is given.

Authorization for release of information may be revoked in writing at any time; in not revoked, consent will expire 90 days after termination of treatment or upon this date/condition:

_____

☐ In such cases as is necessary, I authorize Practical Life Counseling to fax my treatment records.

_____ _____
Signature of Client, Parent/Guardian Date

_____ _____
Signature of Therapist Date

Rev: 3/2020

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Electronic Communications Policy

- No form of electronic communication is considered 100% secure. As such, Ms. Rees and Practical Life Counseling cannot guarantee protection from unathorized attempts to access, use, or disclose personal information exchanged electronically, via phone call, text message, or email. Additionally, these forms of communication are not compliant with the Health Insurance Portability and Accountability Act (HIPAA).

- You may elect to communicate via email or text messaging for issues regarding scheduling and administrative issues. Text message and email should not be used to discuss therapeutic content if you expect total confidentiality. This does not prohibit you from using these forms of communication with Ms. Rees; if you opt to use text or email to discuss therapeutic content, there is no guarantee of absolute confidentiality.

- Your therapist is ethically and legally obligated to maintain records of each time we meet, talk on the phone, or correspond via electronic communication. A judge can subpoena your records for a viariety of reasons, and if this happens, you therapist must comply. You should also be aware that any email sent to your therapist from a computer in a work-place environment is legally accessible by your employer.

- Emails may become a part of the client record when it contains therapeutic information or when you wish it to be used as a part of your therapy. A copy will be printed and put in your chart in these cases.

- Your therapist does not accept requests from current or former clients on personal social networking sites. Practical Life Counseling does have a Facebook page to share pertinent articles, encouraging messages, and insights from Ms. Rees. You are welcome to follow/like this professional Facebook page and read or share the posts from that page. However, by doing so you understand that this may compromise your confidentiality.

- Between session contact with Ms. Rees is normally limited to short messages regarding scheduling or issues with fees. Longer contact is possible by arrangement, and the charge will be prorated per your session fees. Phone calls lasting longer than 15 minutes will be considered as additional counseling service; they will be documented and billed accordingly.

- If you wish to publicly reveal information related to your therapy through electronic communication with your counselor, it is requested that you consult with your counselor before doing so.

I have read and understand the above disclaimers:

Authorized Signature: _____ Date: _____

Rev 5/4/2020

Tina Marie Rees

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Social Justice Discount

Social Justice Discounts reflect Ms. Rees' belief that all people deserve quality healthcare, but not all are able to obtain quality healthcare.

Due to financial constraints, _____ is unable to afford

- ☐ The full fee for private pay counseling
- ☐ The copay amount related to their insurance
- ☐ The fee negotiated by their insurance company during the term of their deductible and has requested a Social Justice Discount.

After discussion, Ms. Rees has agreed to reduce fees as described below:

- ☐ Full free for private pay counseling discounted by $ _____; charge for weekly session is $ _____.
- ☐ Copay, as contracted with _____ discounted by $ _____; charge for copay is $_____.

This Social Justice Discount will remain in place for the duration of counseling or until the client experiences a significant change in their finances, at which time this agreement will be reviewed and potentially altered or cancelled altogether.

Signature: _____ Date:_____

Guardian Signature (for minors only):_____ Date:_____

Witness:_____ Date:_____

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Secure Storage, Transfer, and Access of Records

Policy and Procedure for Storage:

1. All active client files will be kept in a locked file cabinet located in the practice office of the client's clinician.

2. Recently discharged / closed files will be kept in a locked file cabinet in the practice office for six to twelve months after date of termination/suspension of services, after which all records will be scanned and stored electronically; the physical copy of the records will be shredded and destroyed.

3. In accordance with Arizona laws (ARS 12-2297) concerning client records, electronic copies of the client files will be preserved for six years after the closure of the client's case.

Policy and Procedure for Transfer & Access of Records

1. In the event that Ms. Rees retires, all records will be scanned and stored electronically; the physical copy of the records will be shredded and destroyed. Ms. Rees will retain possession of the electronic copy of the records, and in accordance with Arizona laws (ARS 12-2297) will retain the electronic copy for six years after closure of the client's case.

2. In the event of sudden death or disability, all physical and electronic counseling records will be retained by Ms. Rees' family and may be retrieved for up to six years after the last date Ms. Rees was actively seeing clients by requesting those records in writing.

All patients may have access to their files in accordance with the provisions described in the practice's Notice of Privacy Practices and the federal Health Insurance Portability and Accountability Act of 1996.

A fee of $.25 per page will be charged by Ms. Rees or her family to cover the cost of printing or copying records to comply with the exact nature of any records request. If mailing costs are also incurred, this fee will also be paid by the client and must be paid in full prior to the release of the records.

All records request must be made in writing to the following address.

Practical Life Counseling
7650 S. McClintock Road Suite 103-289
Tempe, AZ 85284

PRACTICAL LIFE COUNSELING

Your Information. Your Rights. My Responsibilities.

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

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of my responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information I have about you. Ask me how to do this.
- I will provide a copy or a summary of your health information, usually within 30 days of your request. I may charge a reasonable, cost-based fee.

Ask me to correct your medical record

- You can ask me to correct health information about you that you think is incorrect or incomplete. Ask me how to do this.
- I may say "no" to your request, but I'll tell you why in writing within 60 days.

Request confidential communications

- You can ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- I will say "yes" to all reasonable requests.

Ask me to limit what I use or share

- You can ask me not to use or share certain health information for treatment, payment, or my operations. I am not required to agree to your request, and I may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask me not to share that information for the purpose of payment or my operation with your health insurer. I will say "yes" unless a law requires me to share that information.

Get a list of those with whom I've shared information

- You can ask for a list (accounting) of the times I've shared your health information for six years prior to the date you ask, who I shared it with, and why.
- I will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked me to make). I'll provide one summary of all disclosures at no cost to you each year but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. I will provide you with a paper copy promptly.

YOUR INFORMATION, YOUR RIGHTS, MY REPONSIBILITIES

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
- I will make sure the person has this authority and can act for you before I take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting me. I will listen to all of your complaints and respond in writing within 30 days.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, SW, Washington, DC 20201 or by calling 1-877-696-6775.
- I will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell me your choices about what I share. If you have a clear preference for how I share your information in the situations described below, talk to me. Tell me what you want me to do, and I will follow your instructions.

In these cases, you have both the right and choice to tell me to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell me your preference, for example if you are unconscious, I may go ahead and share your information if I believe it is in your best interest. I may also share your information when needed to lessen a serious and imminent threat to health or safety.

I will never sell your information for marketing purposes, nor will I share your psychotherapy notes unless you give me written permission.

USES AND DISCLOSURES

How do I typically use or share your health information? I typically use or share your health information in the following ways:

Treat you

I can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run my practice

I can use and share your health information to run my practice, improve your care, and contact you when necessary.

Example: I use health information about you to manage your treatment and services.

Bill for your services

I can use and share your health information to bill and get payment from health plans or other entities.

Example: I give information about you to your health insurance plan so it will pay for your services.

YOUR INFORMATION, YOUR RIGHTS, MY REPONSIBILITIES

How else can I use or share your health information?

I am allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. I have to meet many conditions in the law before I can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

I can share health information about you for certain situations. These situations are all defined by law:

- If you are a danger to yourself or have threatened the safety of others
- If you are abusing a child or a vulnerable adult/elderly person
- Reporting suspected abuse, neglect, or domestic violence

Comply with the law

I will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that I am complying with federal privacy law.

Work with a medical examiner

I can share health information with a coroner or medical examiner when an individual dies.

Address workers' compensation, law enforcement, and other government requests

I can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

I can share health information about you in response to a court or administrative order, or in response to a subpoena.

My Responsibilities

- I am required by law to maintain the privacy and security of your protected health information.
- I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- I must follow the duties and privacy practices described in this notice and give you a copy of it.
- I will not use or share your information other than as described here unless you tell me in writing that I can. If you tell me that I can share your information, you may change your mind at any time. Let me know in writing if you change your mind.

Changes to the Terms of this Notice

I can change the terms of this notice, and the changes will apply to all information I have about you. The new notice will be available upon request, in my office, and on my web site.

This notice is effective as of 5/1/2020.