A Place to Talk, LLC; Luisa V Nagore, MS, NCC, LPC, CCTS-I
Tel: (520) 375 - 9039 Email: aplacetotalkservices@hotmail.com
4646 E. Ft Lowell Rd, St 105, Tucson, AZ 85712
NPI: 1669986808

Treatment Plan – Contract for change

Name: Date:

Welcome!

I understand that creating a treatment plan or identifying goals may feel difficult to pinpoint "right of the bat". However, it is important that we both know why you are here and how can I help you. Given my experience I have come up with some possible goals for your treatment. These are not set in stone; you can change gears at any time, but we do need a starting point.

Now, you need identify at least 1 goal (not more than 5) you would like to achieve during this episode of care. You can check of any of the goals on the following list that you feel fit you best **OR** you can write your on goals.

"I want to build self-awareness, confidence (a measure of faith of your own abilities), and self esteem (a sense of self)".

"I want to address my decision-making process for problem solving purposes while learning about boundaries".

"I want to explore and regulate expectations of self and others in my life (including but not limited to loved ones, friends, coworkers, or acquaintances)".

"I want to Identify the multiple roles you play in multiple scenarios".

"I want to learn about my feelings and how to manage them".

"I want to learn how to set boundaries for myself and with others".

"I want to learn how to communicate effectively with others".

"I want to live an authentic life".

"I want to address my gender identity and/or my sexual identity".

SPECIFIC THERAPY GOAL(s)/Objective (s):

1.

2.

3.

4.

5.

This counseling plan will be reviewed at the termination of therapy or at least one year from this date on _____.

My signature indicates I have participated in the development of this counseling plan and agree with the recommended goals and interventions.

_____

Print & Sign Date

_____

Luisa V Nagore, LPC Date

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Demographics form

Today's Date:

- Legal Name (s) of person (s) seeking treatment:
- Date of birth:
- Social Security number (needed if payment is through insurance):
- Preferred contact information:
  - Cell: Work: Email:

If you choose to use texting, please download OhMD app (it is free to you) for HIPPA secure texting purposes (HIPPA is the Health Insurance Portability and Accountability Act to protect medical/mental health information). **NOTE:** A Place to Talk, LLC (APTT, LLC) uses Google Voice phone services. Please be aware that if you text APTT, LLC at 520 375 9039, the information you send is NOT protected by HIPPA. If you are having an emergency during afterhours, please contact 911.

- Address:
- Tell me the name you want me to use when I address you:
- Sex assigned at birth (PND- prefer to not disclose):
- Gender identity (PND- prefer to not disclose):
- Pronouns (PND- prefer to not disclose):
- Sexual orientation (PND- prefer to not disclose):

- Race/Ethnicity (PND- prefer to not disclose):
- Preferred language:
- Marital/partner status:
- Significant others:
  - Spouse or partner's name (s):
  - Children:
- Are you seeking individual counseling or couples counseling? Know that it is counterproductive (and unethical) to see two different counseling providers at the same time. You are welcome to do consultation and then decide who you chose as your provider.
- How did you find my practice?
- **Emergency contact**:
  - Name:
  - Relationship to you:
  - Contact No.

The person you list here will be contacted in case of emergency only, for example (but not limited to) when posing a threat to self or others, consideration of inpatient assessment/treatment, and lack of contact after no show/no call a month after last session. Minimal disclosure will be used at time of contact.

PLEASE READ AND COMPLETE THIS SECTION IN DETAIL.

Use the information provided to you via call, email, or text regarding your insurance verified benefits.

All payments are due at the time of service.

- Forms of payment:

- Cash
- Bank transfer via **Zelle** using aplacetotalkservices@hotmail.com
- Credit/Debit cards (HSA/FSA) a **$5 fee will be charged in addition** to the cost of the session when using a card.

Please be mindful of your time and mine: Same day cancellation fee $50.

- **Self-Pay**: $_____ per session. **Write the fee** agreed with Luisa Nagore, LPC.

- **Insurance information:**

Company name, ID, and group number:

Co-payment:

Note: Verification of benefits does not guaranty payment. You will be notified of any discrepancies in between the information provided during verification of benefits and actual insurance payments upon remittances received by A Place to Talk, LLC.

Print & Sign Date

Luisa V Nagore, LPC Date

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Presenting issue and treatment history

Date:

Name: _____

Age: _____ Date of birth: _____

- Reason (s) seeking treatment:

- Check current symptoms:

Restlessness	Worry	Flashbacks
Loss of interest	Sweats	Detachment
Feeling empty	Isolation	Hypervigilance
Worthlessness	Self-critical	Negative beliefs
Sadness, tearful	Breathing rapidly	Startle responses
Trouble thinking	Shortness of breath	Intrusive memories
Feeling hopeless	Difficulty controlling	Distressing dreams
Sleep disturbance	Urge to avoid "things"	Problem concentrating
Guilt and/or shame	Increased heart rate	Negative expectations
Feeling weak or tired	Gastrointestinal problems	Persistent fear, horror, anger
Changes in eating habits	Sense of impending danger	Irritability/irritable behaviors
Frequent or recurrent thoughts of death, suicidal thoughts, suicide attempts or suicide.		
Unexplained physical problems, such as back pain or headaches.		
Substance abuse/drug of choice:		

- History of **mental health treatment**: Please include name of facility, length of service, and type of service (inpatient, IOP, outpatient, individual counseling, therapeutic or support groups.

- History of **medical treatment**: Please include name of facility, length of service, and type of service: Inpatient and/or outpatient services.

- Last physical was completed on _____ .

- Current providers:

  - PCP - Name & phone number:

- Current Medications (medical, psychotropic, and supplements/homeopathic):

Name	Dosage	Taken for	Prescriber

- Adverse reactions to ANY medications/drugs?

- To the best of your knowledge, have you ever been treated for or had an indication of:

Visual disturbances, dizziness, severe headaches, weakness or paralysis or arms and legs, fainting, strokes?	Y / N
Respiratory related conditions?	Y / N
Disorders of the eyes, ears, or throat?	Y / N
Chest pains, rheumatic fever, heart murmur, palpitations, high blood pressure?	Y / N
Gastrointestinal related conditions?	Y / N
Increased urinary frequency, pain or burning urination, passing blood in urine, history of kidney stones or urinary tract infection, diabetes?	Y / N
Rashes, chronic skin disorders, arthritis, or gout?	Y / N
Any known thyroid condition?	Y / N
Blackouts, convulsions, seizures, epilepsy? None related to substance use.	Y / N
Syphilis, gonorrhea, herpes, HIV/AIDS, or other sexually transmitted disease?	Y / N

Female body:

- Do you experience physical and/or emotional difficulties prior to or during your period? If yes, please explain: Yes No

- How many times have you been pregnant?
  - Number of pregnancies carried to full term.
  - Infertility issues? Yes No
  - Miscarriage (s)? Yes No ---- Abortion (s)? Yes No
  - Any complications (including emotional) or current concerns?

- Have you experienced menopause? Yes No

- Have you begun having symptoms of menopause (hot flashes, irregular/missed periods, sleep disturbance, unusual mood changes)? Yes No

- If yes, please describe:

- Indicate Employment history:

Currently employed at/since

- Prior employment:

- Highest level of education attained:

- History of substance use: (substance(s) of choice, frequency & how long have you used):

- Indicate any history of involvement with the law.

- Military Services:

- Trauma history – Keep in mind that "trauma" is not limited to experiencing one isolated traumatic event. It can be low intensity but high frequency, for example covert bullying. **CHECK** what applies to you

Childhood Adult (Domestic Violence, elder abuse, etc.) Past/current

Physical abuse Sexual abuse Emotional abuse Severe childhood neglect

- Tell me a <u>little bit</u> about this history:

- Family Dynamics: Do you have a good relationship with parents, siblings, or not? And so forth.

- Spiritual and/or cultural preferences?

Please note any additional information you believe to be pertinent to A Place to Talk services.

Note: I am a mandated reporter, this means that I am legally required to report any suspicion of child abuse,(even though I do not work directly with minors) and senior abuse, or neglect to the relevant authorities.

Thank you for providing this information.

Print & Sign	Date
Luisa V Nagore, LPC	Date

PATIENT HEALTH QUESTIONNAIRE-9
(PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

GAD-7 Anxiety

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer"*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Column totals: ___ + ___ + ___ + ___

Total Score _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

GAD-7 total score for the seven items ranges from 0 to 21. This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively.

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**…
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**…
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 _____

4. Did you **often or very often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often or very often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers:_____This is your ACE Score.

092406RA4CR

Borderline Symptom List 23 (BSL-23)

Code:_____ **Date:** _____

Please follow these instructions when answering the questionnaire: In the following table you will find a set of difficulties and problems which possibly describe you. Please work through the questionnaire and decide how much you suffered from each problem in the course of the last week. In case you have no feelings at all at the present moment, please answer according to how you *think you might have felt*. Please answer honestly. **All questions refer to the last week. If you felt different ways at different times in the week, give a rating for how things were for you on average.**

Please be sure to answer each question.

In the course of last week...		not at all	a little	rather	much	very strong
1	It was hard for me to concentrate	**0**	**1**	**2**	**3**	**4**
2	I felt helpless	**0**	**1**	**2**	**3**	**4**
3	I was absent-minded and unable to remember what I was actually doing	**0**	**1**	**2**	**3**	**4**
4	I felt disgust	**0**	**1**	**2**	**3**	**4**
5	I thought of hurting myself	**0**	**1**	**2**	**3**	**4**
6	I didn't trust other people	**0**	**1**	**2**	**3**	**4**
7	I didn't believe in my right to live	**0**	**1**	**2**	**3**	**4**
8	I was lonely	**0**	**1**	**2**	**3**	**4**
9	I experienced stressful inner tension	**0**	**1**	**2**	**3**	**4**
10	I had images that I was very much afraid of	**0**	**1**	**2**	**3**	**4**
11	I hated myself	**0**	**1**	**2**	**3**	**4**
12	I wanted to punish myself	**0**	**1**	**2**	**3**	**4**
13	I suffered from shame	**0**	**1**	**2**	**3**	**4**
14	My mood rapidly cycled in terms of anxiety, anger, and depression	**0**	**1**	**2**	**3**	**4**
15	I suffered from voices and noises from inside or outside my head	**0**	**1**	**2**	**3**	**4**
16	Criticism had a devastating effect on me	**0**	**1**	**2**	**3**	**4**
17	I felt vulnerable	**0**	**1**	**2**	**3**	**4**
18	The idea of death had a certain fascination for me	**0**	**1**	**2**	**3**	**4**
19	Everything seemed senseless to me	**0**	**1**	**2**	**3**	**4**
20	I was afraid of losing control	**0**	**1**	**2**	**3**	**4**
21	I felt disgusted by myself	**0**	**1**	**2**	**3**	**4**
22	I felt as if I was far away from myself	**0**	**1**	**2**	**3**	**4**
23	I felt worthless	**0**	**1**	**2**	**3**	**4**

Now we would like to know in addition the quality of your **overall** personal state in the course of the last week. 0% means **absolutely down**, 100% means **excellent**. Please check the per- centage which comes closest.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
(very bad) ←									→	**(excellent)**

BSL - Supplement: Items for Assessing Behavior

	During the last week.....	Not at all	once	2-3 times	4-6 times	Daily or more often
1	I hurt myself by cutting, burning, strangling, headbanging etc.	**0**	**1**	**2**	**3**	**4**
2	I told other people that I was going to kill myself	**0**	**1**	**2**	**3**	**4**
3	I tried to commit suicide	**0**	**1**	**2**	**3**	**4**
4	I had episodes of binge eating	**0**	**1**	**2**	**3**	**4**
5	I induced vomiting	**0**	**1**	**2**	**3**	**4**
6	I displayed high-risk behavior by knowingly driving too fast, running around on the roofs of high buildings, balanc- ing on bridges, etc.	**0**	**1**	**2**	**3**	**4**
7	I got drunk	**0**	**1**	**2**	**3**	**4**
8	I took drugs	**0**	**1**	**2**	**3**	**4**
9	I took medication that had not been prescribed or if had been prescribed, I took more than the prescribed dose	**0**	**1**	**2**	**3**	**4**
10	I had outbreaks of uncontrolled anger or physically at- tacked others	**0**	**1**	**2**	**3**	**4**
11	I had uncontrollable sexual encounters of which I was later ashamed or which made me angry.	**0**	**1**	**2**	**3**	**4**

WE THANK YOU VERY MUCH FOR YOUR PARTICIPATION! PLEASE RETURN THE QUESTIONNAIRE TO YOUR THERAPIST

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COMMUNICATION REQUEST FORM

I authorize A Place to Talk, LLC staff and / or any designated business associates to contact me in the following way(s) and at the following location(s):

- By phone (home, work and/or Cell phone) at: _____
  Specific instructions (leave first name only, leave phone number only, appointment, time, place, and confirmations).

- Cell Phone/ **Texting (NEEDS OhMd)** at**:** _____
  Specific instructions (leave first name only, leave phone number only, appointment, time, place, and confirmations).

- Via E-Mail at: _____
  Specific instructions (leave first name only, leave phone number only, appointment, time, place, and confirmations).

- By mail at: _____
  Specific instructions (no return address on envelope, stamped *Confidential* etc.)

Other Location / Method at:

Specific instructions:

_____

Print & Sign Date

_____

Luisa V Nagore, LPC Dat

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Release of Information

I, _____, authorize A Place to Talk, LLC to:

a) Release information to b) Obtain information c) Both

Name of individual/organization: _____

Address: _____
City State Zip code
Telephone:_____ Fax:_____

Email:_____Relationship:_____

The information released and/or obtained is confidential and to be used only for the purposes of coordinating efforts with other treatment providers.

Exceptions regarding information I authorize to be released:

- ☐ No exceptions
- ☐ Information regarding substance use
- ☐ Information related to HIV/AIDS

This authorization is effective for one year or from
_____/_____/_____ to _____/_____/_____.

I understand that I can revoke this authorization at any time.

- ☐ **Revoked on:_____**

_____
Print & Sign Date

_____
Luisa V Nagore, LPC Date

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Clinical Records Protocol

1. If the practice of Luisa Nagore, A place to Talk, is terminated or sold, all clients who have received services from this practitioner within the past seven years will receive a written letter with the information stated below.
2. This letter will be sent to the client 30 days prior to termination or selling of the practice.
3. The letter will include the current phone number and or address to contact the Practitioner. In the case of untimely death, the responsibility of contacting clients will be given to the executor of the will.
4. A good faith effort will be made to contact any client who has been seen within the past seven years. This good faith effort is defined as a written letter. If there is not response to the letter, a phone call will be made. If the contact information is no longer accurate, an attempt to get updated information will be made through the Internet.

The letter will inform the client how to reach Luisa or her representative, by phone or email, to obtain their records. It will also let them know that all records will be kept for six months following the sending of the letter.

5. If the client has made no contact after six months, the records will be shredded by Luisa or her representative to maintain confidentiality.
6. If contact has been made, Luisa will respond to the client's request within 30 days. Records will be sent by registered mail to the address provided by the client.

_____

Print & Sign Date

_____

Luisa V Nagore, LPC Date

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INFORMED CONSENT FOR TELEPSYCHOLOGY

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.
- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.
- Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.
- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications

We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with me should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you

do not either. Also, I may delay in checking my email or texts, nor do I respond immediately, so these methods **should not** be used if there is an emergency.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on holidays or other types of leave. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence if necessary.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Informed Consent still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telepsychology

From time to time, we may schedule in-person sessions to "check-in" with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, Crisis Response Center (520) 622-6000 or 1 (866) 495-6735 or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on the phone number I provided you (520) 261-1289.

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Fees

The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.

Records

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

_____

Print name and sign Date

_____

Luisa V Nagore, LPC Date

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Notice of Privacy Practices

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

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.
As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordination, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend you protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective foe all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written compliant with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies or procedures of our office. We will not retaliate against you for filling a complaint.

Please contact us for more information: For more information about HIPPA or to file a complaint: The U. S. Department of Health & Human Services Office of Civil Rights 200 Independence Ave., S.W. Washington, D.C. 20201; (202) 619-0257; Toll Free: 1-877-696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy or a more detailed copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions but if you do agree then are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I **attempted to obtain patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:**

Date:	**Initials:**	**Reason:**