New Patient Packet - Children Ages 7 - 12

Packet includes:

(1) Personal History Questionnaire - Children Ages 7 - 12
(2) Office and Practice Polices
(3) No Show or Cancellation Policy/ Controlled Substance and Prescription Refills
(4) Acknowledgements and Informed Consent
(5) Authorization for Insurance Information
(6) Authorization to Use/Disclose Protected Health Information
(7) HIPAA Privacy Notices

Instructions

Please read, sign, and complete all pages of this packet before your first appointment.

- ☐ (1) Complete the Personal History Questionnaire
- ☐ (2) Read the Office and Practice Policies
- ☐ (3) Read and sign the No Show or Cancellation Policy/ Controlled Substance and Prescription Refills
- ☐ (4) Read, initial, and sign Acknowledgements and Informed Consent
- ☐ (5) Complete the Authorization for Insurance Information, if applicable
- ☐ (6) Read and sign Authorization to Use/Disclose Protected Health Information, if necessary
- ☐ (7) Read the HIPAA Privacy Notices

Please make sure to bring this completed packet as well as your identification and any other requested information to your first appointment.

Personal History Questionnaire - Children Ages 7 - 12

Form completed by: Date:

Patient Name:	DOB:	Age:	Gender:
Address:	City:	State:	Zip:
Patient telephone:	Social security #:		
Guardian 1 Name:	Relationship to patient: ☐ Mother ☐ Father ☐ Other:		
☐ Address same as patient primary address			
Primary address:	City:	State:	Zip:
Telephone:	Alt phone:	Parent/guardian social security #:	
May we leave a message: ☐ yes ☐ no	Email:		
Ok to contact by email: ☐ yes ☐ no	How did you hear about us? Referring provider?		
Guardian 2 Name:	Relationship to patient: ☐ Mother ☐ Father ☐ Other:		
☐ Address same as patient primary address			
Primary address:	City:	State:	Zip:
Telephone:	Alt phone:	Parent/guardian social security #:	
May we leave a message: ☐ yes ☐ no	Email:		
Ok to contact by email: ☐ yes ☐ no			
Alternative emergency contact:	Relationship:	Phone:	
Preference for appointment reminders (choose one): ☐ Email:	☐ Call:	☐ Text:	
Name of current therapist/psychiatric provider:	Phone:		

Please provide the names, ages, and relationships of those living with the patient.		
Name	Age	Relationship to you
Please list the names and ages of any siblings not living with the patient:		

REASON(S) FOR VISIT

Describe your reason for making this appointment:
Describe any recent changes that may be contributing to this issue:
Why do you think the patient has this issue?
When did patient first experience this issue?

MENTAL HEALTH/PSYCHIATRIC HISTORY

Please mark any symptoms that patient is experiencing now or has experienced in the past.

NOW	PAST		NOW	PAST		NOW	PAST	
☐	☐	depressed/sad mood	☐	☐	social anxiety	☐	☐	relationship issues
☐	☐	reduced interest in activities	☐	☐	obsessions	☐	☐	eating problems
☐	☐	sleeping too much or too little	☐	☐	compulsions	☐	☐	drug/alcohol problems
☐	☐	low energy/fatigue	☐	☐	excessive fears	☐	☐	gambling problems
☐	☐	appetite/weight change	☐	☐	irritability	☐	☐	sexual problems
☐	☐	crying spells/ tearfulness	☐	☐	anger outbursts	☐	☐	computer addiction
☐	☐	low self-esteem	☐	☐	abnormally elevated mood for several days	☐	☐	work/school issues
☐	☐	low motivation	☐	☐	racing thoughts	☐	☐	parenting issues
☐	☐	social isolation	☐	☐	excessive energy			
☐	☐	hopelessness	☐	☐	rapid speech/ talkativeness	Other (please describe):		
☐	☐	loneliness	☐	☐	hyperactivity			
☐	☐	guilt/shame	☐	☐	impulsivity			
☐	☐	feeling restless or slowed down	☐	☐	distractibility			
☐	☐	poor concentration	☐	☐	interrupting others			
☐	☐	difficulty thinking or making decisions	☐	☐	flashbacks			
☐	☐	seasonal mood changes	☐	☐	nightmares			
☐	☐	thoughts of dying	☐	☐	easily startled			
☐	☐	frequent anxiety or nervousness	☐	☐	suspiciousness/ paranoia			
☐	☐	excessive worry	☐	☐	hearing or seeing things			
☐	☐	panic symptoms	☐	☐	impaired memory			
☐	☐	muscle tension	☐	☐	forgetful			

Are any of the above symptoms affecting:

☐ daily activities ☐ school ☐ housing ☐ finances ☐ legal issues ☐ relationships ☐ health

Has patient been diagnosed with a mental health/psychiatric condition in the past? ☐ yes ☐ no		
Diagnosis	Age or dates treated	By whom

Please list medications taken for mental health reasons.			
Name of medication	Dosage	How long?	Did it work/side effects/concerns

Please list any outpatient treatment (therapy or medication management with PCP or mental health provider)		
Name/place	Approximate dates	Outcome/experience

Has patient received inpatient psychiatric treatment? ☐ yes ☐ no When? Reason:
Has patient ever engaged in self-harming behavior? ☐ yes ☐ no When? How?
Has patient ever attempted suicide? ☐ yes ☐ no When? How?

FAMILY HISTORY			
	Relationship to patient	Age of diagnosis	Treatment?
Depression			
Anxiety			
Bipolar (manic depressive)			
Post-traumatic stress			
Schizophrenia/psychosis			
ADHD/ADD			
Suicide or attempt			
Dementia			
Trauma/abuse			
Incarceration			
Substance abuse			
Other (specify):			

GENERAL MEDICAL HISTORY

Primary Care Provider (PCP):		
PCP Address:		
Phone:	Fax:	Date of last visit:
Reason for last visit:		
Lab work in past year?	Height:	Weight:
Allergies to medication/other:		
Medical conditions:	Last menstrual period, if applicable: Birth control:	
Surgeries and dates:		

Please list all current prescription medications, over-the-counter medications, herbal and nutritional supplements:

Name	Dosage/frequency	Purpose	Prescriber

Does patient exercise regularly? ☐ yes ☐ no How often?

What kind of exercise?

Describe what patient ate yesterday:

Any concerns about eating habits?

Any concerns about body image/weight?

Any history of binging/purging or restricting diet? ☐ yes ☐ no
If so, please describe:

Techniques to cope with stress:

Hobbies/activities:

Please check any of the following conditions that patient currently has, has had in the past, or that family members have had. (Please include parents, siblings, children, aunts/uncles, grandparents)				
	Current?	Past?	Family history?	Relationship to patient?
Anemia	☐	☐	☐	
Asthma	☐	☐	☐	
Cancer	☐	☐	☐	
Chronic pain	☐	☐	☐	
Diabetes	☐	☐	☐	
Head injury	☐	☐	☐	
Heart disease	☐	☐	☐	
High blood pressure	☐	☐	☐	
High cholesterol	☐	☐	☐	
HIV+	☐	☐	☐	
Kidney disease	☐	☐	☐	
Liver disease	☐	☐	☐	
Seizures/epilepsy	☐	☐	☐	
Stomach/GI problems	☐	☐	☐	
Thyroid disease	☐	☐	☐	
Other (specify):	☐	☐	☐	

SOCIAL HISTORY			
Please check any factors present during your childhood/adolescence:			
☐ Divorce/separation	☐ Physical abuse	☐ Domestic violence	Other:
☐ Frequent moves	☐ Sexual abuse	☐ Parental unemployment	
☐ Family member disability	☐ Emotional abuse	☐ Parental illness	
☐ Death in the family	☐ Crime victim	☐ Financial stress	

Where was patient born and raised? By whom?
Was patient full term baby? ☐ yes ☐ no Gestational age at birth: Complications during pregnancy/delivery: Birth weight: Known substance exposure in utero? ☐ cigarettes ☐ alcohol ☐ drugs - list: Met developmental milestones on time? ☐ yes ☐ no
Current relationship with siblings?
Current relationship with parents/guardians?
Does patient have close friendships? Any concerns about social skills/behavior?
Favorite activities: How may hours per day on: TV _____ Computer _____ Video games _____ Other screens _____
Grade level: School: IEP/504 plan?
Describe any chores patient is responsible for:
Please list any legal history (arrests, convictions, DHS involvement, custody, guardianship): ☐ none
Please describe your ethnic, cultural, and/or religious or spiritual background:
Additional concerns:

Guardian signature **Date**

328 S Central Ave, Suite 101 Box 2, Medford, OR 97501
Tel (541) 414-4966
Fax (541) 816-4600

Office and Practice Policies

This document is to familiarize you with our office and practice policies. Please read them carefully and if you have any questions, discuss them with your provider. Your signature at on the Authorizations and Informed Consent document signifies that you have read, understand, and agree to abide by these policies and that you have received a copy for your records.

Appointments: Initial appointments are 60 minutes. Follow-up appointments are 30 minutes. Please arrive on time as late arrival may require that your appointment be rescheduled. Please give at least 24 hours notice if you need to cancel or reschedule an appointment. If an appointment is missed or cancelled within 24 hours you will be charged a fee of $100.00. If you "No Show" and do not contact our office to reschedule your appointment within 30 days of your missed appointment this will be considered as termination of services by you, the patient, therefore refills will not be provided.

Billing: Payment in full is due at the time that services are rendered. If you have a balance due on your account, payment will need to be paid in full by the end of the month, unless other arrangements have been made with our office. Refusal to arrange payments or to pay in full as services are provided will result in suspension of services until the bill is paid in full and/or termination of services. Your account may be turned over to an attorney or to a collection agency for collection and you will be held responsible for any legal or collection costs.

Children: We are unable to provide supervision for any children that may accompany you to your appointment. Children may not be left unattended in the waiting area. Discussions with your provider are often sensitive in nature, so please make sure to arrange for child care if necessary.

Communication: We check our messages daily and attempt to return calls within 24 hours. We are unable to accept or return telephone messages to anyone not covered on the Authorization to Use/Disclose Protected Health Information form. Please sign a release ahead of time if you would like friends, family, other providers or significant others to be able to communicate about your service or care.

Confidentiality and Release of Information: Your participation in treatment and all information about you is confidential and will not be disclosed to anyone without your written consent. The only exceptions are: 1) Cases where your provider believes the client presents a clear and imminent danger to him/herself or to another person, 2) Cases where a court subpoenas your provider to testify or subpoenas his/her records, 3) Cases where an insurance company is helping to pay the fee and requires information about diagnosis and/or reports about treatment, 4) Cases where an emergent decision needs to be made in the absence of consent but where clinical information is needed to make this decision.

E-mail: We go to every effort to keep your confidentiality secure. We recommend using phone communication for your confidential personal issues rather than e-mail. Unsecured e-mail is not a guaranteed confidential

means of communication. If you use unsecured e-mail to communicate health needs they must be of a non-urgent medication or appointment change need. We are not always connected to our e-mail and may not check it daily. Urgent needs must be handled over the phone including suicidal ideation, medications, side effects, prescriptions, etc.

Emergencies: In case of a life-threatening emergency call 911 or go to the nearest emergency room. To reach your nearest mental health crisis line, please call:

Jackson County	(541) 774-8201	**Josephine County**	(541) 474-5360

Other mental health/community crisis numbers for those receiving telehealth services:

Baker County	(541) 519-7126	**Lane County**	(541) 687-4000
Benton County	1(888) 232-7192	**Lincoln County**	1(866) 266-0288
Clackamas County	(503) 655-8585	**Linn County**	(541) 967-3866
Clastop County	(503) 325-5724	**Malheur County**	(541) 889-9167
Columbia County	(503) 397-5211	**Marion County**	(503) 585-4949
Coos County	(541) 751-2550	**Morrow County**	911
Crook County	(541) 323-5330	**Multnomah County**	(503) 988-4888
Curry County	1(877) 519-9322	**Polk County**	(503) 581-5535
Deschutes County	(541) 322-7500	**Sherman County**	1(888) 877-9147
Douglas County	1(800) 866-9780	**Tillamook County**	(503) 842-8201
Gilliam County	911	**Umatilla County**	1(866) 343-4473
Grant County	911	**Union County**	(541) 962-8800
Harney County	(541) 573-8376	**Wallowa County**	(541) 426-3111
Hood River County	1(888) 877-9147	**Wasco County**	(541) 296-6307
Jefferson County	(541) 475-6575	**Washington County**	(503) 81-9111
Klamath County	(541) 883-1030	**Wheeler County**	911
Lake County	(541) 947-6021	**Yamhill County**	1(800) 560-5535

National Suicide Prevention LifeLine 1-800-273-TALK (1-800-273-8255)

Fees: There is no charge when you call or leave a message. However, calls that require more than 10 minutes to complete may be billed $50.00 per fifteen minutes. Reports for insurance companies, disability insurance, and work related reports are billed at the hourly rate of $150.00 per hour. We encourage clients to make an appointment so you and your provider can write the report together. The fee for non-sufficient funds (NSF) is $35.00. After a second NSF check you must pay for future appointments with cash, money order or credit card.

HIPAA Privacy Notice: We are committed to preserving the privacy of your personal health information. Additionally, we are required by Federal Law (Health Insurance Portability and Accountability Act, known as HIPAA) and by State Law to protect the privacy of your personal information and to give you a Notice that describes (a) how clinical information about you may be used and disclosed and (b) how you can get access to this information. A copy of the HIPAA Privacy Notice is included in this packet for your records.

Insurance: You are responsible to check with your insurance company regarding your coverage and to track this coverage as your treatment progresses. Some things to keep in mind are: Are you currently covered? What is your annual deductible? What is your percent of coverage? What is the maximum benefit for outpatient mental health coverage? What coverage is available for out-of-network services? If we are out-of-network for your insurance plan, we will provide an itemized bill that you may submit to your insurance company for reimbursement based on your available benefits.

Medication Management and Safety: All medication has potential to cause side effects as well as interact with other prescriptions/over-the-counter medications or herbal remedies. However, there is no way of testing what effects a medication will have on a specific person. Please be advised that medication used in psychiatry are often prescribed “off-label” meaning they are used to treat/manage symptoms other than what the FDA originally approved them for. This will be discussed during treatment planning and risks and benefits and alternative will be discussed before setting a treatment plan. It is important to let your provider know about changes in your medications including prescription, herbal, and over-the-counter.

Payment: We currently accept cash, checks, Visa, Mastercard, Discover, and American Express. The fee for an NSF check is $35.00. Please contact us for payment arrangements on any outstanding balance. In the event that your account must be referred to a third party for collection, you agree to pay all reasonable collection and/or attorney fees, as well as court costs incurred.

Prescriptions and Refills: Prescriptions will be written only during scheduled appointments. You are responsible for rescheduling in a timely manner. If you are unable to keep an appointment and are running low on your medication, contact your pharmacy and ask them to fax a refill request to (541) 816-4600. You must have a timely follow up appointment scheduled and a quantity of medication may be provided until that time. Refill requests will be handled during our regular business hours and are not considered an emergency. Allow three business days to process. Any medication changes will also be addressed during your appointment. Controlled substance prescriptions will only be provided during scheduled appointments.

Services Not Provided: We do not provide court evaluations or court testimony as it may seriously undermine the therapeutic relationship. Inform us immediately if you are currently involved or plan to be involved in legal proceedings. By entering into treatment with us, you are agreeing not to involve Aspire Mental Health and Wellness LLC and its providers in legal/ court proceedings including child custody, workers compensation claims, or criminal cases. Our providers are not trained in and do not provide forensic (court) evaluations. Due to the office environment, we are unable to provide treatment for sex offenders, persons with impulse control disorders, or persons with violent criminal histories. Our providers also reserve the right to refer you to a more appropriate provider if you need more intensive services than they can provide.

In the event that we are subpoenaed, we will make every attempt to protect your confidentiality, but as outlined in the Office and Practice Policies above, be advised that there may be limitations. Please note that we will charge for our testimony, including travel time, wait time, copies of records, and preparation/consultation time. ***We will charge current legal rate as well as expenses incurred in copying and sending records. You will be responsible for these fees as they are not covered by insurance companies.***

No Show or Cancellation Policy

Cancellation of Appointment

Please be courteous and contact us promptly if you are unable to keep your appointment. This time will be reallocated to another client who is in urgent need of treatment or on a waiting list. If you need to cancel or reschedule your appointment, we require that you give us at least 24 business hours notice.

How to Cancel Your Appointment

To cancel your appointment, call (541) 414-4966 and leave a detailed message or send an e-mail to info@aspiremhw.com.

Late Cancellation and No Show Fees

A "no show" is a patient who misses an appointment without at least 24 hours advance notice. For example if your appointment is at 3pm on Friday you need to call by 3pm on Thursday to cancel. If your appointment falls on a Monday, you need to cancel it by the Friday before your appointment. If you "no show" or late cancel you will be charged a $100.00 fee. This fee will need to be paid in full before scheduling any further appointments.

Multiple "no show" appointments confirm that the patient/provider relationship is not working well. Therefore, after three missed appointments, our "no show" policy allows us to terminate your care. A letter may be sent, though not required, giving you a 30-day written notice that we will no longer be responsible for your care.

Controlled Substance Prescriptions and Refills

Medication Prescriptions and Refills

Clients who receive any prescriptions for controlled substances must be seen at least once every three months and may require monthly visits depending on your treatment plan. If it has been more than three months since your last appointment, you will need to make an appointment before any prescriptions will be written.

Controlled prescriptions will only be provided during a scheduled in-person appointment.

I have read this policy and understand it.

_____ _____

Patient or Representative Signature **Date**

_____

Relationship to patient

Acknowledgements and Informed Consent

Patient name: _____ Patient DOB: _____

Acknowledgment of Office and Practice Policies

_____ I have received, read, understand, and agree to the office policies as outlined in the Office and Practice Policies statement for Aspire Mental Health and Wellness LLC.

Consent for Treatment

_____ I freely and voluntarily consent to treatment provided by Aspire Mental Health and Wellness LLC. I understand that I have the right to terminate my participation at any time.

HIPAA Receipt and Release

_____ I have been given opportunity to review and keep a copy of our HIPAA Privacy Notice. I have received, read, understood and had the opportunity to ask us any questions about this policy.

Financial Policy

_____ Payment is due at the time that services are rendered. I understand that I am financially responsible for all charges and for any appointment that I fail to keep or cancel with less than 24 hours (at least one business day's) notice prior to that appointment time. I acknowledge that any money credited as overpayment due to me will be refunded after completion of treatment.

Use of Email

_____ I request that Aspire Mental Health and Wellness LLC use email as a form of communication as deemed necessary and appropriate. I acknowledge that unsecured email is not a secure method of communication. Secured email may be used for communications involving protected health information.

Billing and Insurance

For billing purposes, I authorize the below the person(s) to discuss insurance and/or payment.

_____ Print Name: _____ Relationship: _____
_____ Print Name: _____ Relationship: _____

My signature below verifies my agreement to all initialed agreements above.

_____ _____
Patient or Representative Signature **Date**

_____
Relationship to patient

Authorization for Insurance Information

I, the undersigned, assign directly to Aspire Mental Health and Wellness LLC all medical benefits.

I hereby authorize Aspire Mental Health and Wellness LLC to treat my medical/psychiatric needs and to release all information necessary to obtain authorizations for services, to coordinate care, and to secure the payment of benefits.

_____ (initials required) Insurance now REQUIRES separate authorization for release of information regarding drug or alcohol use diagnoses and treatment for ALL patients receiving psychiatric/behavioral health care. By initialing here, you consent to release of information related to drug and alcohol use diagnoses and treatment necessary to obtain authorizations for services, to coordinate care, and to secure the payment of benefits.

As a courtesy, Aspire Mental Health and Wellness LLC will bill my insurance company. I authorize Aspire Mental Health and Wellness LLC to bill my insurance company and accept payment from that company on my behalf for all services relating to my care. I understand that I am financially responsible for all charges not covered by my insurance and for any appointment that I fail to keep or cancel with less than 24 hours (at least one business day's notice) prior to that appointment time.

I agree to pay any portion of the bill that I am responsible for, including copayments and deductibles. I agree to pay the 30% collection fee on top of my owed amount should my bill not be paid timely and require being sent to collections. I certify that a photocopy of this agreement is as valid as the original and my signature indicates agreement with these terms.

If the client is under 18 years of age a parent or guardian is required to be present at the appointments and must sign below giving authorization of treatment.

Name of Primary Insurance Company:_____

ID/Policy #:_____ Group #:_____ Co-Pay Amount: $_____

Insurance Company Address:_____

City/State/Zip:_____

Insurance Company Phone Number:_____

Subscriber's Full Name:_____ DOB:_____

Subscriber's SSN:_____ Relationship to Patient:_____

Subscriber's Address:_____

City/State/Zip:_____

Subscriber's Phone Number:_____

Subscriber's Employer Name:_____

We do not process claims for secondary insurance. The balance due after the primary insurance company has paid is the responsibility of the client. The client can file a claim for reimbursement of payment from their secondary insurance company.

Signature _____ Date_____

Aspire Mental Health and Wellness LLC
328 S Central Ave, Suite 101 Box 2, Medford, OR 97501
Phone: 541-414-4966
Fax: 541-816-4600

Authorization to Use/Disclose Protected Health Information

_____ _____
Patient Name DOB

I hereby authorize the use or disclosure of my personal health information as described below.

INFORMATION TO BE RELEASED

TO: _____ FROM: _____
Name Name

_____ _____
Address Address

_____ _____

INFORMATION TO BE RELEASED (check one):

____ The most recent two years of pertinent information (chart notes, labs, x-rays, and diagnostic tests)
____ All medical records
____ Specific information (please specify):

PURPOSE FOR WHICH DISCLOSURE IS BEING MADE (check one):

____ Doctor ____ Insurance ____ Personal ____ Attorney ____ Other (specify): _____

PATIENT AUTHORIZATION

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment) **I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released.** I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

_____ _____
Patient or Representative Signature Date

_____
Relationship to patient

HIPAA Privacy Notice
Notice of Privacy Practices
Effective Date: September, 2013

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.

What is this Notice? Who will follow this Notice and Why is it Important? As of April of 2003, a new federal law ("HIPAA") went into effect. This law requires that health care practitioners create a notice of privacy practices for you to read. This notice tells you how Aspire Mental Health and Wellness LLC will protect your medical information, how this information may be used or disclosed, and describes your rights. If you have any questions about this notice, please contact the Privacy Officer directly at Aspire Mental Health and Wellness LLC.

Understanding Your Health Information During each appointment, we record clinical information and store it in your chart. Typically, this record includes a description of your symptoms, your recent stressors, your medical problems, a mental status exam, any relevant lab test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your medical or health record, serves as a basis for planning your care and treatment. Typically we may use your health information and share it in order to:

- *Treat you and communicate with other professionals who are treating you.*

  For example: Your primary care physician or your psychotherapist might call us to discuss your treatment, and in that situation we would disclose information about your diagnosis, your medications, and so on.

- *Run our practice, improve your care, and contact you when necessary.*

  For example: Occasionally, we dictate notes from visits, usually for letters to other clinicians. In that case, your health information will be disclosed to the transcriptionist.

- *Bill and get payment from health plans or other entities.*

  For example: In order to get paid for our services, we have our billing office send a bill to you or your insurance company. The information on the bill may include information that identifies you, as well as your diagnosis, and type of treatment. In other cases, we fill out authorization forms so your insurance company will pay for extra visits, and this includes some information about you, including your diagnosis. We use an electronic health record which may also include information that identifies you including specific health information.

We may be allowed or required to use your information in other ways- usually ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumer/index.html. These additional uses and disclosures may include:

- Sharing health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety.
- Using or sharing your information for health research.
- Sharing 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 we are complying with federal privacy law.
- Sharing information about you with organ procurement organizations.
- Sharing information with a coroner, medical examiner, or funeral director when an individual dies.
- Using or sharing health information about you for worker's compensation claims, for law enforcement purposes or with 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.
- Sharing information about you in response to a court or administrative order in response to a subpoena.

Your Health Information Rights You have the following rights related to your medical record:

- *Obtain a copy of this notice*.
  You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- *Authorization to use your health information*.
  Before I use or disclose your health information, other than as described in this notice, I will obtain your written authorization, which you may revoke at any time to stop future use or disclosure.
- *Access to your health information*.
  You may ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- *Change your health information*.
  You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- *Request confidential communications*.
  You may request that when we communicate with you, we do so in a specific way (e.g. at a certain mail address or phone number). We will make every reasonable effort to agree to your request.
- *Accounting of disclosures*.
  You may request a list of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- *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.
- *Ask us to limit what we use or share*.
  You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we 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 us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- *File a complaint if you feel your rights were violated*.
  You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the US Department of Health and Human Services for Civil Rights by sending a letter to 200 Independence Ave, SW, Washington, DC 20201, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Our Responsibilities

- We are required by law to protect the privacy of your health information, to provide this notice about our privacy practices, and to abide by the terms of this notice.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We reserve the right to change our policies and procedures for protecting health information. When we make a significant change in how we use or disclose your health information, we will also change this notice.
- Except for the purposes related to your treatment, to collect payment for our services, to perform necessary business functions, or when otherwise permitted or required by law and as described above, we will not use or disclose your health information without your authorization. You have the right to revoke your authorization at any time.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Will We Disclose Your Health Information to Family and Friends? While the new law allows such disclosures without your specific consent (as long as it contributes to your treatment), our office policy is that we will generally not share your clinical information with your family without a signed authorization from you. The exception to this is if we believe you pose an immediate danger to yourself or someone else—in that case, we will do whatever is necessary, even if that means breaching confidentiality.

For More Information or to Report a Problem. If you have questions, would like additional information, or want to request an updated copy of this notice, you may contact us at Aspire Mental Health and Wellness LLC at any time. If you feel your privacy rights have been violated in any way, please let us know and we will take appropriate action.

You may also send a written complaint to:
Department of Health & Human Services, Office of Civil Rights
Hubert H. Humphrey Building 200 Independence Avenue
S.W. Room 509 HHH Building
Washington, D.C. 20201