



NEGAR TASLIMI, PSYD CLIENT INTAKE FORM (MINOR)

(Please Print)

Today's date: _____

1. IDENTIFICATION

Client's last name:	First:	Middle:	Birth date:	Age:	Gender:
			/ /		<input type="checkbox"/> M <input type="checkbox"/> F

Guardian's last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
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Street address:	Social Security no.:
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P.O. box:	City:	State:	ZIP Code:
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Home phone no.:	May I leave you a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cell phone no.:	May I leave you a message? <input type="checkbox"/> Yes <input type="checkbox"/> No
()	May I identify myself by name? <input type="checkbox"/> Yes <input type="checkbox"/> No	()	May I identify myself by name? <input type="checkbox"/> Yes <input type="checkbox"/> No

I give you permission to mail me a termination letter at the aforementioned address. Yes No

Occupation:	Employer:	Employer phone no.:
		()

Primary Care Physician:	PCP Phone no.:
	()

Referred by (please check one box): Dr. _____ Insurance Plan Hospital
 Family Friend Close to home/work Internet/Social Media Other

List of people living in child's home (Name, Age, Relation):

Child's grade level:	Name of child's teacher:
Child's ethnic identification (optional):	Child's religious/spiritual background (optional):

EMERGENCY CONTACT

Name of local friend or relative (not living at same address):	Relationship to child:	Home phone no.:	Work phone no.:
		()	()

By providing this information, you are authorizing **Negar Taslimi, PsyD** to contact this person in the case of an emergency.

 Client/Guardian signature

 Date

2. PRESENTING PROBLEM

What are the main problems, symptoms and current stressors that your child seeks treatment for?



When did the issues arise? Was there an event that made these issues surface?

- Degree problem(s) has affected your child's life: Low Moderate High Extreme
- Rate your social/economic status: Poverty Lower-Middle Middle Upper-Middle Upper
- Is your financial situation stressful? Low Moderate High Extreme

What do you expect to achieve from therapy/ what are your goals?

3. MEDICAL HEALTH HISTORY

- | | |
|---|--|
| Does your child have a balanced diet? <input type="checkbox"/> Yes <input type="checkbox"/> No | Does your child exercise regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has there been any change in your child's weight recently? <input type="checkbox"/> Yes <input type="checkbox"/> No | If so, how much weight has he/she gained or lost? |
| When was your child last examined by a physician? | What were the findings? |

If applicable, please provide a list of any medications your child is currently taking:

List any serious injuries, surgeries, hospitalizations, major medical issues your child has had with their dates:

Which of the following conditions has your child, previously or currently, been diagnosed with?

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures or convulsions | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hypoglycemia (low blood sugar) |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory loss | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Fainting spells/blackouts | <input type="checkbox"/> Allergies | <input type="checkbox"/> Thyroid difficulties | <input type="checkbox"/> Other heart condition |
| <input type="checkbox"/> Severe or prolonged nausea | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other |

4. MENTAL HEALTH HISTORY

Is your child currently or has he/she ever received psychological or psychiatric treatment of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, please specify the dates and duration he/she received the service(s):
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Is your child currently suicidal? Yes No

Has your child ever been suicidal? Yes No

If yes, when?

Which of the following problems does your child currently have or has he/she previously experienced?

- | | | |
|--|---|--|
| <input type="checkbox"/> Depression/Sadness | <input type="checkbox"/> Lonely | <input type="checkbox"/> Gambling |
| <input type="checkbox"/> Suicidal ideas | <input type="checkbox"/> Excessive worry | <input type="checkbox"/> Unusual thoughts or beliefs |
| <input type="checkbox"/> Always sleepy/tired | <input type="checkbox"/> Shy with people | <input type="checkbox"/> Poor living conditions |
| <input type="checkbox"/> Sleep difficulties | <input type="checkbox"/> Can't make friends | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Self-inflicted pain or injury | <input type="checkbox"/> Flashbacks/intrusive recollections | <input type="checkbox"/> Recurrent dreams |
| <input type="checkbox"/> Lacks motivation/energy | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Unable to have a good time | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Sexual problems |



- | | | |
|---|--|---|
| <input type="checkbox"/> Extreme mood swings | <input type="checkbox"/> No appetite | <input type="checkbox"/> Learning disability |
| <input type="checkbox"/> Feel hopeless | <input type="checkbox"/> Over-eating | <input type="checkbox"/> Over-ambitious |
| <input type="checkbox"/> Anxiety/Nervousness | <input type="checkbox"/> Inferiority feelings | <input type="checkbox"/> Occupational problems |
| <input type="checkbox"/> Unable to relax | <input type="checkbox"/> Feel worthless | <input type="checkbox"/> Relational problems |
| <input type="checkbox"/> Feel tense | <input type="checkbox"/> Aggression/violence | <input type="checkbox"/> Behavioral difficulties |
| <input type="checkbox"/> Fears and phobias | <input type="checkbox"/> Criminal behavior | <input type="checkbox"/> Difficulty focusing/paying attention |
| <input type="checkbox"/> Can't make decisions | <input type="checkbox"/> Recurrent conflicts with others | <input type="checkbox"/> School phobia |
| <input type="checkbox"/> Obsessions | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Enuresis/encopresis |

Which of the following symptoms has any member of **your child's family** experienced?

- | | | |
|--|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Unusual thoughts or beliefs | <input type="checkbox"/> Criminal behavior/incarcerated |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Attention deficit hyperactivity disorder | <input type="checkbox"/> Aggression/violence |
| <input type="checkbox"/> Extreme mood swings | <input type="checkbox"/> Developmental delays | <input type="checkbox"/> Learning disability |
| <input type="checkbox"/> Alcohol or drug abuse | <input type="checkbox"/> Suicide | <input type="checkbox"/> Other |

Has any member of your child's family sought out psychological or psychiatric treatment? Yes No

If so, please explain:

5. DEVELOPMENTAL HISTORY

Where was your child born?

How many siblings does your child have? Sisters (include age) Brothers (include age)

What is your child's birth order?

Mother: Living Deceased Age:

Father: Living Deceased Age:

Who is your child's primary caretaker?

How is child disciplined and by whom?

Does your child have difficulties learning at school? If yes, explain:

Describe your child's relationship with his/her siblings:

Describe your child's relationship with primary caretakers:

Were there any significant events or circumstances, which impacted your child's upbringing (many moves, illness, death of a loved one, traumatic injuries or accidents, physical abuse, verbal abuse, sexual abuse, emotional abuse, parents separation/divorce, chronic fighting at home, etc.)? Yes No

If yes, please describe:



6. SUBSTANCE USE HISTORY

	Frequency	Amount	Date Last Used
Caffeine (coffee, tea, sodas)			
Alcohol			
Drugs (include type)			
Sedatives (tranquilizers, sleeping pills)			

Has your child ever been diagnosed or treated for substance abuse or addiction? Yes No
If yes, where and when?

Does any member in your child's family use or abuse drugs or alcohol? Yes No
If yes, please describe their relationship to your child and what substance(s) they were using:

7. LEGAL HISTORY

Is your child currently involved in a civil or legal litigation? Yes No
If so, please explain:

Has your child ever been arrested? Yes No
If so, please explain:

Has your child been court ordered for therapy? Yes No

If there is any other important information that you would like to add that can be helpful in aiding your child's treatment, please provide it here:

MINOR CONSENT FORM & PARENT AGREEMENT TO RESPECT PRIVACY

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

POLICY REGARDING CONSENT FOR TREATMENT OF A MINOR CHILD

Generally, consent from both parents prior to providing treatment to a minor child is required. If any questions exist regarding the authority of representative to give consent for psychotherapy, I will require that the child's representative submit legal documentation, such as a custody order, prior to the beginning of treatment.

WHAT TO EXPECT

The purpose of attending psychotherapy is to help you cope with difficult life circumstances in a non-judgmental and safe environment with the guidance of a therapist. When we meet, we will discuss your goals for therapy and the presenting problem(s). I will ask questions, listen to you and propose a plan to meet your goals for therapy. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling.

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

CONFIDENTIALITY CANNOT BE MAINTAINED WHEN

- You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.
- You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, and I must inform the person who you intend to harm.
- You are doing things that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

- You tell me you are being abused-physically, sexually or emotionally-or that you have been abused in the past. In this situation, I am required by law to report the abuse to the Department of Children and Family Services.
- You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement *unless* the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

COMMUNICATING WITH YOUR PARENT(S) OR GUARDIAN(S)

Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.

Even if I have agreed to keep information confidential - to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

COMMUNICATING WITH OTHER ADULTS

School: I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission. A very unlikely situation might come up in which I do not have your permission but both I and your parent or guardian believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information.

Doctors: Sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a counselor or therapist. I will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don't have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

RISKS AND BENEFITS OF THERAPY

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undergo treatment. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased

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skills for managing stress, resolutions to specific problems and improved self-confidence. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your Part. In order to be most successful, you will have to work on things we discuss outside of sessions.

A minor client will benefit most from psychotherapy when his/her parents, guardians, or other caregivers are supportive of the therapeutic process.

CANCELLATION POLICY

If a session needs to be cancelled or rescheduled, I ask that the client's representative provide me with 24 hours' notice. If a session is missed without cancelling, or is cancelled with less than 24 hours' notice, my policy is to collect the full amount of the session payment. Client's representative is responsible for payment of the agreed upon fee for any missed session(s).

It is important to note that insurance companies do not provide reimbursement for cancelled sessions. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES

The standard fee for service is \$____ per 50 minute session. Sessions longer than 50 minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Client will be notified of any fee adjustment in advance. Payment must be made by check, cash, or credit card. Any checks returned to my office are subject to an additional fee of up to \$25 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. You are expected to pay for services at the time services are rendered.

CLIENT LITIGATION

I will not voluntarily participate in any litigation or custody dispute. I will not generally write or sign letters, reports, declarations, or affidavits to be used in legal matter. I will generally not provide records or testimony unless compelled to do so. In the case that I am subpoenaed, or ordered by a court of law, to appear as a witness in action involving you, you are expected to pay me for any time spent preparing, traveling, or other time in which I make myself available at my usual rate of \$____ per 50 minutes.

PSYCHOTHERAPISTS-PATIENT PRIVILEGE

Typically, the client is the holder of the psychotherapist-patient privilege. If I am subpoenaed for records, deposition testimony, or testimony in a court of law, I will assert the psychotherapist-patient privilege until I am instructed to do otherwise in writing by a person with authority to waive the privilege on client's behalf. When a client is a minor child, the holder of psychotherapist-patient privilege is either the minor, a court appointed guardian, or minor's counsel. Parents typically do not have the authority to waive the psychotherapist-patient privilege for their minor children, unless given such authority by a court of law. Client/representative should be

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aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. If client/representative has any concerns in regards to the psychotherapist-patient privilege he/she should discuss it with his/her attorney.

INSURANCE

Since I am currently not a participating provider for your insurance plan, I can provide you with a receipt of payment for services. You can submit the receipt to your insurance company for reimbursement. Please note that not all insurance companies provide reimbursement for fees already paid.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Client's records are maintained in a secure location in the office. I keep brief records noting that client was here, client's reasons for seeking therapy, the goals and progress we set for treatment, client's diagnosis, topics we discussed, client's treatment history, records I receive from other providers, copies of records I send to others, and client's billing records. Except in unusual circumstances that involve danger to client, client has the right to a copy of his/her file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that client initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse his/her request for access to your records, client has a right to have my decision reviewed by another mental health professional, which I will discuss with client upon his/her request. Client also has the right to request that a copy of his/her file be made available to any other health care provider at his/her written request.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about client's privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. Client has been provided with a copy of that document and we have discussed those issues. Please remember that client may reopen the conversation at any time during our work together.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING ME

Client/representative may leave a message on my confidential voicemail and your call will be returned as soon as possible. It may take me one to two business days to return your call on non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, call 911 and ask to speak to the mental health worker

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on call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice. The following resources are available in the local community for individuals in crisis:

Crisis Hotline: (877) 727-4747

Youth Shelter: (949) 494-4311

Domestic Violence Help: (800) 799-7233

Rape Crisis Hotline: (714) 957-2737

Hospital: (714) 771-8113

General Resources: 211

SOCIAL NETWORKING AND INTERNET SEARCHES

I do not accept requests to add current or former clients on social networking sites. Communicating via any interactive social networking websites or applications can potentially compromise your privacy and confidentiality. Thus, it is best to avoid such interactions.

THERAPEUTIC PROCESS

I intend to assist client in reaching client's personal goals. I may provide treatment recommendations. Psychotherapy is most effective when the therapist and client work together and have open communication with one another. Client have the right to disagree with any recommendations I make. I will periodically provide feedback in regards to your progress. I cannot predict the length of treatment due to the varying nature and severity of problems and the individuality of each client. Also I cannot guarantee a specific outcome from treatment.

TERMINATION OF THERAPY

The length and eventual termination of treatment depends on client's progress and the specifics of his/her treatment plan. It is recommended to plan for the termination of treatment with me. Treatment may be terminated for the following reasons: untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, client's needs are outside of my scope of competence or practice, or client is not making adequate progress in therapy. It is recommended that client participate in at least one termination session in order to reflect on the work that has been done and to facilitate a positive termination. If it is needed or applicable, I will ensure a smooth transition to another therapist by providing client/representative with referrals.

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ACKNOWLEDGEMENT

By signing bellow, client's representative acknowledges that he/she has read this Agreement and the Notice of Privacy Practices and agrees to their terms. Representative agrees to abide by the terms and conditions of this Agreement and consents to have client participate in psychotherapy with me.

Client Name (please print)

Signature of Client (if client is 12 or older)

Date

Signature of Representative (and Relationship to Client)

Date

Signature of Representative (and Relationship to Client)

Date

I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payer.

By providing the information below, you authorize me to keep the following credit card information on file and to charge this credit card for payment of services rendered,, missed appointments or appointments canceled/rescheduled without **24 hours' notice**, copays, and outstanding balances.

Credit Card #: _____ Type: _____

Expiration Date: _____ Security Code: _____ Billing Zip Code: _____

Name of Responsible Party (Please print)

Signature of Responsible Party

Date

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Parent/Guardian:

Check boxes and sign below indicating your agreement to respect your adolescent's privacy:

- I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.
- Although I know I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my adolescent's treatment.
- I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

Parent/ Guardian's Signature

Date

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NOTICE OF PRIVACY

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.

I am required by law to maintain the privacy and security of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice"). I must abide by the terms of this Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website. Except for the specific purposes set forth below, I will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving me written notice of your revocation.

Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent. I can use and disclose your PHI without your Authorization for the following reasons:

1. For your treatment. I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist, I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me an Authorization to do so.
2. To obtain payment for your treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company to be paid for the health care services that I have provided to you, although my preference is for you to give me an Authorization to do so.
3. For health care operations. I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

Certain Uses and Disclosures Require Your Authorization:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
 - a. For my use in treating you.
 - b. For my use in training or supervising other mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
 - c. For my use in defending myself in legal proceedings instituted by you.
 - d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
 - e. Required by law, and the use or disclosure is limited to the requirements of such law.
 - f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
 - g. Required by a coroner who is performing duties authorized by law.
 - h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

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Certain Uses and Disclosures Do Not Require Your Authorization. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

Certain Uses and Disclosures Require You to Have the Opportunity to Object:

Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

You have the following rights with respect to your PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or

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(949) 478-5763

for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think I may have violated your privacy rights, you may file a complaint with me, as the Privacy Officer for my practice. You can also file a complaint with the U.S.Department of Health and Human Services Office for Civil Rights by:

1. Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;
2. Calling 1-877-696-6775; or,
3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

I will not retaliate against you if you file a complaint about my privacy practices.

EFFECTIVE DATE OF THIS NOTICE: This notice went into effect on August 1, 2017.

I have read this NOTICE OF PRIVACY PRACTICES and have received a copy.

Patient Name (please print)

Signature of Patient (or authorized representative)

Date