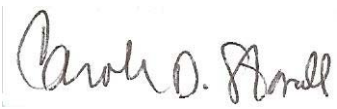
Behavioral Health First, Inc.

Dear Client:

We care about you and your treatment. So, in accordance with new federal laws, we are providing you with our practice Privacy Notice. We are required under a new federal law to provide you with this notice. As you well know, by the nature of our business, we need to collect and maintain personal information. We recognize our obligation to keep this information secure from improper disclosure and the enclosed notice details how we keep your personal information confidential.

Your individual therapist will be happy to answer any questions you may have regarding this notice.

Sincerely,



Carole D. Stovall, Ph.D.
Principal

This package includes:

* Privacy Notice
* Acknowledgment of Receipt of Privacy Practices
* Registration Form
* Insurance Information Form
* Authorization for Release of Health Information

4501 Connecticut Avenue, NW ● Suite 215 ● Washington, DC 20008 ● 202-237-7179

Behavioral Health First, Inc.
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WASHINGTON, DC NOTICE FORM

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *written authorization*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"
  – *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  – *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  – *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.
- "*Authorization*" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when we are asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- ***Child Abuse*** – If we know or have reasonable cause to suspect that a child known to us in my professional capacity has been or is in immediate danger of being a mentally or physically abused or neglected child, we must immediately report such knowledge or suspicion to the appropriate authority.
- ***Adult and Domestic Abuse*** – If we believe that an adult is in need of protective services because of abuse or neglect by another person, we must immediately report this belief to the appropriate authorities.
- ***Health Oversight Activities*** – If the D.C. Board of Psychology is investigating us or our practice, we may be required to disclose PHI to the Board.
- ***Judicial and Administrative Proceedings*** – If you are involved in a court proceeding and a request is made for information about the professional services we provided you and/or the records thereof, such information is privileged under D.C. law, and we will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- ***Serious Threat to Health or Safety*** – If we believe disclosure of PHI is necessary to protect you or another individual from a substantial risk of imminent and serious physical injury, we may disclose the PHI to the appropriate individuals.
- ***Worker's Compensation*** – If we are treating you for Worker's Compensation purposes, we must provide periodic progress reports, treatment records, and bills upon request to you, the D.C. Office of Hearings and Adjudication, your employer, or your insurer, or their representatives.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. On your request, we will send your bills to another address.)
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You may be denied access to Psychotherapy Notes if we believe that a limitation of access is necessary to protect you from a substantial risk of imminent psychological impairment or to protect you or another individual from a substantial risk of imminent and serious physical injury. We shall notify you or your representative if we do not grant complete access. On your request, we will discuss with you the details of the request and denial process.
- ***Right to Amend*** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.
- ***Right to a Paper Copy*** – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

- If the psychologist intends to revise his/her policies and procedures, he/she must describe in the notice to patients how the psychologist will provide patients with a revised notice of privacy policies and procedures (e.g., by mail, e-mail).

V. Questions and Complaints

If you have questions about this notice, disagree with a decision made about access to your records, or have other concerns about your privacy rights, you may contact:

Dr. Carole Stovall
4501 Connecticut Ave., NW – Suite 215
Washington, DC 20008
(202) 362 - 7594

If you believe that your privacy rights have been violated and wish to file a complaint with *our* office, you may send your written complaint to:

Dr. Carole Stovall
4501 Connecticut Ave, NW – Suite 215
Washington, DC 20008

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

The US Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
(877) 696 – 6775 [toll-free]

VI. Effective Date, Restrictions and Changes to Privacy Policy

In the future, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a written revised notice during your session or by U.S. Mail.

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Acknowledgment of Receipt of Privacy Practices

I, _____ have received a copy of Behavioral Health First's Notice of Privacy Practices with an effective date of April 14, 2003.

Name of Patient: _____

Address of Patient: _____

_____

Signature of Patient: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____

Date: _____

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Washington, DC 20008
(202) 237-7179

Registration Form

Your cooperation in completing this form will be helpful in planning services for you. All information will be treated confidentially. Please print clearly.

NAME: _____DATE: _____

ADDRESS: _____

_____ EMAIL: _____

HOME PHONE: _____WORK PHONE: _____

AGE: _____ DATE OF BIRTH: _____ MARITAL STATUS: _____

EDUCATION (Highest Level Achieved): _____

OCCUPATION: _____

EMPLOYED BY: _____

IN AN EMERGENCY NOTIFY: _____ _____
NAME PHONE

WHO REFERRED YOU TO ME? _____

BRIEFLY DESCRIBE YOUR REASON(S) FOR SEEKING HELP:

_____

_____

WHEN WERE YOU LAST EXAMINED BY A PHYSICIAN? _____

PHYSICIAN: _____ ADDRESS: _____

_____ PHONE: _____

LIST ANY MAJOR HEALTH PROBLEMS FOR WHICH YOU ARE CURRENTLY BEING TREATED: _____

LIST ANY MEDICATIONS YOU ARE NOW TAKING: _____

PREVIOUS PSYCHIATRIC OR PSYCHOLOGICAL THERAPY OR COUNSELING? Yes No

If Yes, Previous Therapists Names & Addresses and Duration (in months) of Treatment:

_____

_____

_____

Fees, Cancellations, Insurance and Emergency Information

FEES: An initial consultation is for 60 minutes and the fee is $_____. Initial testing and assessment costs are approximately $_____, depending on the instruments needed. A single treatment session is typically 45 minutes and the fee is $_____, payable each visit. If you wish to discuss alternate arrangements regarding payment, please do so at your first appointment.

CANCELLATION: **Once an appointment has been arranged, that time slot is reserved for you.** If an emergency occurs and you need to cancel an appointment, you should notify your therapist immediately in order to reschedule your appointment. If this is not possible, you will be charged for the missed appointment, after the second missed time.

INSURANCE: As a courtesy, we are happy to bill your insurance company for you, because we know how stressful life can be. However, please keep in mind that the relationship exists between you and your insurance company. Therefore, you are responsible for understanding and following up on any decisions that are made regarding your policy and benefits. Of course, if there is any way we can be helpful to you in collecting all that is rightfully due you, just ask and we will do our best to help.

EMERGENCIES: If at anytime you feel that your life is in danger because of how you are feeling, call Dr. Stovall and then immediately proceed to the nearest hospital Emergency Room. If you are uncertain about being able to get to the hospital, do not hesitate to call 911, and emergency personnel will assist you.

URGENT, NON-EMERGENCY CALLS: If you do not feel that you are in jeopardy, but would like to speak with Dr. Stovall before your next scheduled appointment, call (202) 362-7594 and leave your name and telephone number (including area code). Dr. Stovall's confidential line is checked regularly. You will receive a call back as soon as possible.

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Please provide a copy, both front and back, of your current insurance card.

Insurance Information:

Insurance Company Name: _____

Address: _____

_____

ID Number: _____ Group Number: _____

Code: _____ Subscriber: _____

Your Relationship to Subscriber (if applicable): _____

Assignment of Benefits:

I authorize benefits under this claim to be paid directly to the provider of services attached, provided that the required tax ID number has been furnished.

_____ _____ _____
Date Patient's Signature SS Number

Authorization:

I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of this or any other necessary information, including medical information, for this or any related claim to the named billing agent. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by myself or by the above named carrier, at any time in writing.

_____ _____ _____
Date Patient's Signature SS Number

Please add any information that you feel may be helpful:

_____

_____

_____

_____

_____

_____

NOTE: An initial consultation is for 60 minutes and the fee is $_____. Initial testing and assessment costs are approximately $_____, depending on the instruments needed. A single treatment session is typically 45 minutes and the fee is $_____, payable each visit. If you wish to discuss alternate arrangements regarding payment, please do so at your first appointment.

Once an appointment has been arranged, that time slot is reserved for you. If an emergency occurs and you need to cancel an appointment, you are requested to notify your therapist immediately in order to reschedule your appointment. **If this is not possible, you will be charged for the missed appointment, after the second missed time.**

_____ _____

Client's Signature Date

_____ _____

Signature of Person Responsible for Payment (if different from Client) Date

If someone other than you is responsible for the bill indicate:

_____ _____

Responsible Party Name Home Phone

_____

_____ _____

Responsible Party Address Work Phone

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

All items on this authorization must be completed or the request will not be honored. Use "N/A" if not applicable.

Patient Name:	_____ (first) (m. initial) (last)
Address:	_____ (street address)
	_____ (city) (state) (zip code)
Medical Record #:	_____ **Birth Date:** _____

For this authorization, "My Health Information" means (check all that apply) and may include information regarding substance abuse treatment:

____ Discharge Summary
____ Outpatient Health Records
____ Mental Health Records
____ Psychosocial Assessment
____ Progress Notes
____ History of Allergies
____ Classroom Observation
____ Diagnostic Test/Results (Lab, X-rays, and other Test Results)/Medications)
____ Verbal Communication
____ Drug & Alcohol Treatment Record
____ Admission History & Physical
____ Operative Report
____ Psychological/Educational Report
____ Other: _____
____ Psychiatric Evaluation/Diagnoses
____ Psychiatric Admission Note
____ Emergency Room Record
____ Pathology Report
____ Immunization Record

For the date(s) of service starting/ending: _____
[insert dates(s) of service requested]

I authorize release of my health Information to:

Behavioral Health First
4501 Connecticut Avenue, NW
Suite 215
Washington, DC 20008

Tel: 202-237-7179

Fax: 202-237-7177

Standard Register HIPAA-33N
Original – Medical Records Copy – Patient/Legal Representative Effec. Date 12/1/10

I understand there may be a charge for copying and handling my request. I understand that all fees will be in compliance with applicable state guidelines. By signing this authorization, I agree to pay these fees at the time this request is made.

I understand that:

- This authorization is voluntary. My treatment will not be impacted, no matter if I sign this authorization or not.
- If I do not sign this authorization, My Health Information will not be disclosed as requested.
- I will receive a copy of this authorization upon signature.
- This authorization is valid for one year from date signed, unless I revoke this authorization or unless an earlier date is specified here: _____. I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization to the Health Care Provider identified above that provided the health information.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature of Patient only: _____ **Date:** _____

(Required)

If you are NOT the patient but are signing on behalf of the patient complete the following:

I, _____**,**
(print your name)

confirm that I am the legally appointed representative for the patient and I have CIRCLED my relationship to the patient below:

- **Parent with Parental Rights**
- **Registered Kinship Care Relative**
- **Medical Power of Attorney**
- **Court Appointed Guardian**
- **Legally Appointed Healthcare Agent**

Representative's Signature: _____ **Date:** _____

(Required)

Address: _____ **Phone:** _____

You must attach proof of your authority to act on behalf of the patient as circled above (other than parent).

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