L + C Psychological Services
Let's Connected

Kirk Little, Psy.D. ▪ President
Suzanne Collins, Psy.D. ▪ President

FACE SHEET

Date: ____/____/20____
Consent form Signed? ___Y___N

Patient Information: Clinician: KL LL TC SC DG JK Release form Signed? ___Y___N

First: _____ MI _____ Last: _____
Address: _____
City/town: _____ State: _____ ZIP: _____
Home Phone: (____) ____-____ Work Phone: (____) ____-____
E-mail: _____ cell: _____
SS#: ___-___-____ Date of Birth: __/__/__ Gender ___M___F

Referred by: _____

Responsible Party Information:

First: _____ MI _____ Last: _____
Address: _____
_____
City/town: _____ State: _____ ZIP: _____
Home: (____)_____ Work: (____)_____ Cell:(____)_____
SS#: ___-___-____ Date of Birth: __/__/__ Gender ___M___F

Primary Insurance Information:

Ins. Co.: _____
ID#: _____ Group #: _____
Policy #: _____ Plan Name: _____
Insured's Name: _____
Address: _____
City/town: _____ State: _____ ZIP: _____
Home Phone: (____) ____-____ Work Phone: (____) ____-____
Insured's SS#: ___-___-____ Date of Birth: __/__/__
Insured's Employer: _____
Deductible: _____ Co-pay Amount: _____
Patient's relationship to insured: ___Self ___Spouse ___Child ___Other _____
Have you called your insurance company to verify benefits and get preauthorization? ___Y___N
If so, Authorization #_____ # of visits approved _____
Dates authorization valid from _____ to _____
If prior Authorization is *required* but not obtained you could ultimately be responsible **for the total balance of the charges.**

6900 Houston Road
Building 500, Suite 11
Florence, KY 41042

Phone: 859.525.4911
Fax: 859.525.6446
www.LCPsych.com

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OUTPATIENT SERVICES AGREEMENT

Welcome to our practice. This document contains important information about our services and business policies. Please review it carefully and discuss any questions with me.

Appointments and Professional Fees: Sessions are typically 45 minutes in length and can be scheduled by phone or in person. Standard charges are:

Initial Appointment	$150
Individual, Family or Couples Therapy	$125
Additional Professional Services (e.g. report writing,, letter writing, completion of forms, telephone calls, attendance at meetings)	$125
Forensic services (e.g. preparation and attendance at any legal proceedings, even if called to testify by another party).	$175
Missed Appointments (For all reasons)* Except Weather	$125
Late Cancellations (For all reasons)*	$125
(Cannot be billed to insurance company. Patient responsible for full amount.)	

_____
INITIAL

***Note:** Your appointment times are specifically reserved for you. Therefore, your must notify me **24 hours in advance** if you need to cancel or reschedule. It typically requires that amount of time to contact other patients to offer them your time slot.

For Parents/Legal Guardians of Child Patients
If parents with joint custody or shared parenting schedule alternating appointments, payment is required at the time of service by the parent scheduled to attend. By signing this agreement, you are assuming full responsibility for all fees and payments, including when another parent with whom you may or may not share custody misses or cancels an appointment without 24 hours notice.

Payment is required at the time of service in all circumstances regardless of who attends the session.

Insurance Reimbursement: If you use health insurance to pay for psychological services, please be aware that you may be responsible for all charges that your insurance company refuses to pay. To avoid a surprise bill from me, you are advised to call your insurance company to confirm what mental health benefits are covered under your plan, and to obtain any required pre-authorizations for services. Bills are distributed approximately once per month, but it may be to your advantage to keep on top of your balance by checking in on a regular basis with billing staff

Most insurance companies require you to authorize me to provide them with a clinical diagnosis from the Diagnostic and Statistical Manual of Mental Disorders. I may have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). I have no control over what they do with this information once it is in their hands. In some cases, they may share the information with a national medical information database.

***Note:** If your account has not been paid for more than 60 days and arrangements for payment have not been made, I may use legal means to secure the payment. This may include hiring a collection agency or going through small claims court. You will be responsible for any fees incurred by said collection agency.

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Contacting Me: The office is typically open from 9:00am to 5:00pm Monday through Friday. The majority of phone calls will be returned on the same day that you make it, with the exception of weekends and holidays. After hours, you will receive a message instructing you which voicemail to choose for routine or emergency messages. If you have a true clinical emergency (e.g. feeling suicidal), leave a message in my emergency voicemail box. If I am available, I will return your call immediately. If I am not immediately available, please call your primary care physician or go to your local emergency room.

Please remember that all phone calls greater than 5 minutes will be charged at the hourly rate prorated in 15 minute increments.

Professional Records: You are entitled to receive a copy of your records unless I believe that seeing them would be emotionally damaging. In this case, I will send them to a mental health professional of your choosing for you to review them together. I may also decide to review them with you before distributing them.

Minors: If you are under 18 years of age, please be aware that the law provides your parents the right to examine your treatment records. I will discuss how to handle this in our first session so that all parties feel comfortable.

Confidentiality: The law protects the privacy of communications between a patient and psychologist. I can only release information to others with your written permission. Exceptions to this include:

- In certain legal proceedings a judge may order testimony if he/she determines that the issues demand it (e.g. child custody).
- If you overtly threaten suicide or homicide, Psychologists are legally obligated to take protective action. This is also true if there is reasonable cause to believe that a child or adult has been abused or neglected. This may include notifying the police or filing a report with the appropriate state agency. There also may be a legal obligation to warn a potential victim or seek hospitalization for the patient.

The full extent of your rights and responsibilities under the Federal HIPPA law is provided in the Kentucky Notice Form, which has been provided to you for your records.

Your signature below indicates that you have read the information in these documents, understand them, and agree to abide by their terms during our professional relationship.

_____ _____

Signed by Patient (if adult) or by Patient's Guardian (if child) | Today's Date

_____ _____

Psychologist | Today's Date

Psychological Services
Life Connected

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Suzanne Collins, Psy.D. ▪ President

LATE CANCEL/MISSED APPOINTMENT FEE AND GUARANTEE OF PAYMENT

I, _____, agree that L+C Psych Services, PLLC will
(Name: Please Print)

bill my credit card for the following:

- **Any MISSED appointment or one that is cancelled with LESS THAN 24 HOURS NOTICE—fee is $125.00, charged day of appointment**
- Any services that have not been paid by myself or my insurance carrier within 60 days of billing
- The original amount plus $15.00 bank fee for bounced checks, charge backs or insufficient funds
- Any work completed for me outside of the normal therapy time (prorated at $125.00/hour)

Missed or late cancelled appointments will be charged the day of the appointment

I will not dispute charges ("charge back") made in accordance with the terms of this authorization.

I understand the authorization is valid for three years or until canceled in writing.

Type of Card: (circle one): Visa Mastercard Discover

Name as it appears on card (please print): _____

Card Number: _____-_____-_____-_____

Expiration Date: _____/_____ CVV2/CID Security Code (back of card) _____

Card Holder's Billing Address:

_____
Street Number City State Zip Code

Card Holder's Signature: _____ Date: _____

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Request for Confidential Handling of Health Information*

*Please complete this form if you have any special requests concerning how our office communicates with you)e.g. Don't call my office, only my home, etc.)

I, _____ request that
(print first and last name of patient/recipient)

L+C Psychological Services handle my confidential health information in the following way:

A. All reasonable requests to receive communication of your health information by alternative means will be granted. Please describe the alternative means (e.g. US mail, telephone call, etc.) by which you prefer to receive your health information.

_____

_____

_____

B All reasonable requests to receive communication of your health information at alternative locations will be granted. Please complete the following section only if you want communications regarding your healthcare information sent to an alternate address.

_____
(Street Address)

_____ _____ _____
(City) **(State)** **(Zip Code)**

_____ _____
(Signature) **(Date)**

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Authorization Form

Patient Name:_____ **DOB:**_____

I authorize L+C Psychological Services to ☐disclose ☐receive ☐exchange confidential information to, from, or with the following persons:

1. **Name**_____ **Phone**_____
   Address _____ **Fax**_____
2. **Name**_____ **Phone**_____
   Address _____ **Fax**_____
3. **Name**_____ **Phone**_____
   Address _____ **Fax**_____
4. **Name**_____ **Phone**_____
   Address _____ **Fax**_____
5. **Other**_____

The purpose of information exchange is: ("at the individual's request" is all that is required if you do not desire to state a specific purpose.)
___At the individual's request
Other_____

This release covers a period of one year unless otherwise stated here.
Expiration date:_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

X Patient Signature:_____ **X Date:**_____

X Parent/Guardian Signature:_____ **X Date:**_____

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ADULT INTAKE
History Questionnaire

Name: _____ Today's Date: ____/____/____

Gender: ❑Male ❑Female Date of Birth: ____/____/____

SS#: _____-_____-_____ Age: _____yrs. _____months

Name of person filling out this form: _____

A. CHIEF CONCERN(S)

1. Please describe why you are here today:

_____

_____

_____

_____

2. What do you hope to accomplish in today's session: _____

_____

_____

B. MENTAL HEALTH HISTORY

1. Have you ever seen a psychologist or therapist or other mental health care provider? ❑Yes ❑No

Name of MD/therapist: _____ Dates of treatment: _____

Name of MD/therapist: _____ Dates of treatment: _____

Name of MD/therapist: _____ Dates of treatment: _____

Name of MD/therapist: _____ Dates of treatment: _____

Name of MD/therapist: _____ Dates of treatment: _____

2. Have you ever been in the hospital or other facility for a behavior or mental health problem? ❑Yes ❑ No

Name of Facility	Age	Days in Facility	How helpful was it to you?
_____	_____	_____	❑great ❑good ❑so-so ❑not at all
_____	_____	_____	❑great ❑good ❑so-so ❑ not at all
_____	_____	_____	❑great ❑good ❑so-so ❑ not at all
_____	_____	_____	❑great ❑good ❑so-so ❑ not at all

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3. Please list any medication(s) you are currently taking for your depression, anxiety, or for other mental health reasons.

Name of Medication	Dosage (mgs)	Times per day	Does it help?
_____	_____	_____	❑a lot ❑a little ❑none
_____	_____	_____	❑a lot ❑a little ❑none
_____	_____	_____	❑a lot ❑a little ❑none
_____	_____	_____	❑a lot ❑a little ❑none
_____	_____	_____	❑a lot ❑a little ❑none

4. Please list any other medication(s) you have taken related to your mental health in the past.

Name of Medication	Dosage (mgs)	Times per day	Did it help?
_____	_____	_____	❑a lot ❑a little ❑none
_____	_____	_____	❑a lot ❑a little ❑none
_____	_____	_____	❑a lot ❑a none
_____	_____	_____	❑a lot ❑a little ❑none

Others_____

C. MEDICAL HISTORY

1. Have you ever had seizures? ❑Yes ❑ No If so, please explain_____
2. Have you ever been knocked out or unconscious from a head injury? ❑ Yes ❑ No what happened?_____
3. Did you have any memory or thinking problems after the injury? ❑ Yes ❑No If yes, explain._____
4. Have you ever had any major ❑ accidents ❑ injuries ❑illnesses ❑ diseases? ❑ None of the above. If yes, please explain. _____

D. FAMILY HISTORY

1. Are you (check all that apply):

❑ Married ❑ Widowed ❑ Separated ❑ Committed Relationship
❑ Single ❑ Remarried ❑ Divorced ❑ Given up on others

2. Have you ever been married? ❑Yes ❑No How many times? _____
3. Do you have any children? ❑Yes ❑No From how many mothers or fathers? _____
4. How old are your children? _____ Do (did) you have custody of them? ❑Yes ❑No
5. Do any of your children have physical or emotional problems? ❑Yes ❑No If yes, please explain _____
6. Has there been any physical violence or abuse in your intimate relationships or marriage(s)? ❑Yes ❑No

7. Who lives in the home with you now (begin with yourself and the adults)?

Name	Relation	Age	Disabled?
_____	_____	_____	❑Yes ❑No
_____	_____	_____	❑Yes ❑No
_____	_____	_____	❑Yes ❑No
_____	_____	_____	❑Yes ❑No
_____	_____	_____	❑Yes ❑No

Siblings

8. How many **bros**___ and **sisters**___ do you have? I am the _____child out of _____kids total. ❑only child

9. Have any of your **Sisters**___ or **Brothers**___ ever had ❑depression ❑ anxiety ❑alcohol abuse ❑ drug abuse ❑disability ❑suicide attempt ❑trouble with the law ❑learning trouble ❑none of the above

Mother

10. How far did your **mother** go in school? ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 ❑ 11 ❑12 ❑Some College ❑ College

11. Does your **mother** have a history of mental health problems? ❑Yes ❑No If yes, please check:
❑Anxiety ❑Depression ❑Suicide Attempt ❑Hospitalization ❑Sexually Abused ❑Physically Abused
❑Domestic Violence ❑Drug use ❑Alcohol abuse ❑ Legal History ❑Other _____

12. Has anyone else on you **mother's** side of the family had a history of mental health problems? ❑Yes ❑No If yes: ❑anxiety ❑depression ❑alcoholism ❑drug abuse ❑problems with the law ❑ other_____

Father

13. How far did your **father** go in school? ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 ❑11 ❑12 ❑GED ❑Some College❑ College

14. Does your **father** have a history of mental health problems? ❑Yes ❑No If yes, please check:
❑Anxiety ❑Depression ❑Suicide Attempt ❑Hospitalization ❑Sexually Abused ❑Physically Abused
❑Domestic Violence ❑Drug use ❑Alcohol abuse ❑ Legal History ❑Other _____

15. Has anyone else on you **father's** side of the family had a history of mental health problems? ❑Yes ❑No If yes: ❑anxiety ❑depression ❑alcoholism ❑drug abuse ❑problems with the law ❑ other_____

16. Did your parents separate or divorce? ❑Yes ❑No How old were you? _____With whom did you stay most? ❑mother ❑father ❑ both ❑other _____

17. Please describe your mother and father's relationship ❑excellent ❑good ❑fair ❑poor ❑hostile ❑no contact

18. What was it like in your family growing up? _____

19. Do you stay in touch with your family members now? ❑Yes ❑No Whom?_____

20. How often do you talk to them? _____

21. Do you get support/comfort from your family members when you are in pain? ❑Yes ❑No

E. TRAUMA HISTORY

1. Have you ever been the victim of emotional abuse? This can include being humiliated or insulted. ❑Yes❑ No

Circle an answer for both as a child and as an adult.	*As a child (<13)*	*As an adult (14 & older)*
a. Has anyone ever exposed the sex organs of their body to you when you did not want it?	❑Yes ❑No	❑Yes ❑No
b. Has anyone ever threatened to have sex with you when you did not want it?	❑Yes ❑No	❑Yes ❑No
c. Has anyone ever touched the sex organs of your body when you did not want this?	❑Yes ❑No	❑Yes ❑No
d. Has anyone ever made you touch the sex organs of their body when you did not want this?	❑Yes ❑No	❑Yes ❑No
e. Has anyone ever forced you to have sex when you did not want this?	❑Yes ❑No	❑Yes ❑No
f. Have you had any other unwanted sexual experiences not mentioned above?	❑Yes ❑No	❑Yes ❑No

If yes, please specify: _____

2. When you were a child (13 or younger), did an older person do the following?

a. Hit, kick, or beat you?	❑Never	❑Seldom	❑Occasionally	❑Often
b. Seriously threaten your life?	❑Never	❑Seldom	❑Occasionally	❑Often

3. Now that you are an adult (14 or older), has any other adult done the following:

a. Hit, kick, or beat you?	❑Never	❑Seldom	❑Occasionally	❑Often
b. Seriously threaten your life?	❑Never	❑Seldom	❑Occasionally	❑Often

4. Did you ever witness or experience any other major, traumatic event in your lifetime? ❑Yes ❑No

❑Domestic violence ❑neglect ❑divorce ❑death(s) ❑loss of loved one(s) ❑catastrophe or natural disaster ❑accident ❑other_____

5. Did you ever have your ❑mother ❑father abandon you? ❑Yes ❑No From ages_____ to _____

F. SOCIAL HISTORY

1. Do you have friends? ❑Yes ❑No If yes, how often do you talk?_____ See them?_____
2. How many *close* friends do you have? _____
3. Have you ever had any trouble getting along with people? ❑Yes ❑No
4. Have you ever had any trouble with: ❑shyness ❑making friends ❑keeping friends ❑bullying others ❑being teased ❑physical fights ❑arguments
5. Who do you talk to most on a typical week? _____
6. Please describe what you do on a typical day for activities:_____

_____

7. What do you do that you enjoy more than anything else?_____

_____

G. LEGAL HISTORY

1. Have you ever been arrested? ❑Yes ❑No In jail? ❑Yes ❑No (please include DUIs and misdemeanors)

2. How many times have you been arrested? ❑1 ❑2 ❑3 ❑4 ❑5 ❑6-10 ❑10-15 ❑ 20 ❑ >25

Date of Arrest	Charge and Punishment	Length of Time Incarcerated

H. DRUG/ALCOHOL HISTORY

1. Have you ever used drugs or alcohol? ❑Yes ❑No If yes, which ones?

❑Alcohol	Age of first use?_____	Date you last used?_____	I drink_____days/wk
❑Marijuana	Age of first use?_____	Date you last used?_____	I smoke_____days/wk
❑Cocaine or crack	Age of first use?_____	Date you last used?_____	I use_____days/wk
❑Benzo's (Xanax, Valium)	Age of first use?_____	Date you last used?_____	I take _____pills/day
❑Heroin	Age of first use?_____	Date you last used?_____	I use _____times/wk
❑Hallucinogens (LSD/Acid)	Age of first use?_____	Date you last used?_____	I use _____times/wk
❑Pain pills (oxy, percoset)	Age of first use?_____	Date you last used?_____	I use _____ times/wk
❑Stimulants (Speed, Ritalin)	Age of first use?_____	Date you last used?_____	I take _____per day
❑I/V drugs	Age of first use?_____	Date you last used?_____	I use_____ times/wk
❑Caffeine (coffee, tea, pop)	Age of first use?_____	Date you last used?_____	I drink _____cups/day
❑Nicotine (cigarettes)	Age of first use?_____	Date you last used?_____	I smoke _____packs/day

_____

_____

2. Have you ever been in the hospital for detox? ❑Yes ❑No If yes, when _____

3. Have you ever gotten into trouble because of drinking or drug use? ❑Yes ❑No _____

4. Have you ever attended Alcoholics Anonymous ❑ (AA) or Narcotics Anonymous ❑ (NA)? ❑No, I have not

5. Have you ever lost friends or girlfriends/boyfriends because of drinking/drug use? ❑Yes ❑No

6. Have people annoyed you by criticizing your drinking or drug use? ❑Yes ❑No

I. EDUCATION HISTORY

1. Where did you go to school? _____

2. What grade did you complete? ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 ❑11 ❑12 ❑Some College ❑college ❑GED _____

3. What were your grades? ❑As ❑Bs ❑Cs ❑Ds ❑Fs

4. Did you ever repeat a grade? ❑Yes ❑No Which one? ❑K ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 ❑11 ❑12

5. How many times did you change schools? ❑None ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑>8

6. Did you receive any special education services? ❑Yes ❑No - Which ones?

❑Classes for Behavior disorder ❑Speech Therapy ❑Tutoring

❑Classes for Learning Disability ❑Resource Room Help

7. In what grade did you begin Special Ed? ❑K ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 ❑11 ❑12

8. Were you ever: ❑suspended from school _____times ❑kicked out of school _____times? ❑ I wasn't

9. Did you get along with your classmates? ❑Yes ❑No – Why not?_____

10. Did you ever do ❑sports ❑clubs ❑activities ❑No, I didn't If yes, which ones?_____

_____

J. MILITARY HISTORY

1. Were you in the military? ❑Yes ❑No Which branch? ❑Army ❑Navy ❑Air force ❑Marines ❑Reserves
2. For how many years? _____ Did you see combat? ❑Yes ❑No Why were you discharged?_____

_____

K. WORK HISTORY

1. How many jobs have you had in your life time? ❑0 ❑1 ❑2-5 ❑6-10 ❑ 11-20 ❑20-30 ❑>30

2. What is your current job or if currently not working, what is the last job you had? _____

Who do you work for? _____ For how long have you worked there?_____

Why did you leave that job? _____

3. Please list other jobs you have held, starting from the most recent and working backward?

Job Title	Employer	Length of employ.	Date Last worked	Reason for leaving

4. Have you had problems getting along with people on the job? ❑Yes ❑No _____

5. Have you had problems getting along with your boss? ❑Yes ❑No _____

6. Have you ever been fired from a job? ❑Yes ❑No If yes, why? _____

L. MISCELLANEOUS

84. Please write anything additional here that you think is important to know about you or your condition _____

****Please complete any other forms ****

The doctor will be with you soon.

FOR OFFICE USE ONLY

J. MENTAL STATUS

Age_____ Cauc.___ AA___ _____M___ F___ Congruent with Age?____ older___ younger___ Obese?____

Dress_____

Hygiene_____

Identifying features_____

Posture/Gait (e.g. non-verbal pain behavior)_____

Mood and affect (e.g. depressed, anxious, manic, constricted, normal)_____

_____

Speech (rate, volume, articulation) _____

Thought process (e.g. loose, blocked) and content (e.g. delusions) _____

_____

Perceptual abnormalities (e.g. hallucinations)_____

_____

Sensorium and cognition (e.g. orientation, recall, concentration)_____

_____

Judgment: ❑Excellent ❑ Good ❑Fair ❑Poor Insight: ❑Excellent ❑ Good ❑Fair ❑Poor _____

_____

Effort/Persistence: ❑Excellent ❑ Good ❑Fair ❑Poor _____

Ability to understand and follow instructions: ❑Excellent ❑ Good ❑Fair ❑Poor_____

Test Results and Interpretation

Test scores Valid? ❑Yes ❑No Why not_____

Scores consistent across measures ❑Yes ❑No Why not_____

Scores consistent with education, vocational background, social adjustment? ❑Yes ❑No _____

Manifestations of the Mental Disorder

_____

_____

_____

_____

_____

_____

_____

Diagnostic Impression

Axis I_____

_____

_____

_____

Axis II_____

_____

Axis III_____

Axis IV_____

Axis V: Current GAF = _____

Prognosis (expected duration with and without treatment)

Summary

Medical Source Statement a)understand, retain and follow instructions, b)sustain attention to perform simple, repetitive tasks, c)Relate to others, including fellow workers and supervisors, d)Adapt (Tolerate the stress and pressures associated with day to day work activity.)

Capability of Managing Finances

Psychological Services
Life Connected

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Suzanne Collins, Psy.D. ▪ President

KENTUCKY 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

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes. 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 I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I 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 my 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 my [office, clinic, practice group, etc.], such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*au*thorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical 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) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

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

- **Child Abuse**: If I have reasonable cause to believe that a child is dependent, neglected or abused, I must report this belief to the appropriate authorities, which may include the Kentucky Cabinet for Families and Children or its designated representative; the commonwealth's attorney or the county attorney; or local law enforcement agency or the Kentucky state police.

  "*Dependent child*" means any child, other than an abused or neglected child, who is under improper care, custody, control, or guardianship that is not due to an intentional act of the parent, guardian, or person exercising custodial control or supervision of the child.

- **Adult and Domestic Abuse**: If I have reasonable cause to believe that an adult has suffered abuse, neglect, or exploitation, I must report this belief to the Kentucky Cabinet for Families and Children.

- **Health Oversight Activities**: The Kentucky Board of Examiners of Psychology may subpoena records from me relevant to its disciplinary proceedings and investigations.

- **Judicial and Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your personal or 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 you communicate to me an actual threat of physical violence against a clearly identified or reasonably identifiable victim or an actual threat of some specific violent act, I have a duty to notify the victim and law enforcement authorities.

- **Workers' Compensation**: If you file a claim for workers' compensation, you waive the psychotherapist-patient privilege and consent to disclosure of your health information reasonably related to your injury or disease to your employer, workers' compensation insurer, special fund, uninsured employers' fund or the administrative law judge.

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, I am 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 me. On your request, I 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 my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I 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. I may deny your request. On your request, I 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, I 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 me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will provide you with a revised notice so that you will become aware of any changes.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact the Kentucky State Board of Psychology Administrator by telephone at (502) 564-3296.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The Administrator listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice so that you will become aware of any changes.