Associates in Brief Therapy, Inc.
Serving Southwest Virginia

ASSOCIATES IN BRIEF THERAPY, INC
4346 Starkey Road, Suite 1
Roanoke, VA 24018
(540) 772-8043

New Patient Information Sheet

(PLEASE PRINT)

Main Office: Roanoke
Satellite Offices: Blacksburg
Daleville
Salem
Floyd

PATIENT INFORMATION:

Patient's Name____
Last Name **First Name** **Middle Initial**

Responsible Party (if a minor) ____

Mailing Address (Street and/or PO Box) ______________________________ **Apt #**__________

City______________________________**State**____________________**Zip Code**__________

Phone: Home ____________________ **Cell** ____________________ **Work** ____________________

Email Address: ______________________________ ❒ Yes, I would like to receive periodic informative emails from ABT, Inc.

Sex: _____**Male** ____**Female** **Date of Birth**__________________ **Age**_________ **Social Security Number**____________________

_____**Single** ______**Married (How long?** ______________________**)** ______**Divorced** ______**Widowed** ______**Separated**

Please list children and their ages: (if applicable)

____

____

Patient Employer____

Address______________________________**City**____________________**State**________**Zip**__________

Occupation____

How or from whom did you hear of ABT? (Name:____**)**

❒ **Doctor** ❒ **Church/Pastor** ❒ **Yellow Pages** ❒ **Current/Former Patient** ❒ **Internet** ❒ **Other** ______________________

In Case of Emergency, Please Contact: ______________________________ **Phone** ____________________

PARENT/SPOUSE INFORMATION:

Spouse/Parent ______________________________ **Date of Birth**____________________

Employer______________________________ **Work Phone**____________________

Occupation______________________________ **Social Security Number**____________________

INSURANCE INFORMATION:

Primary Insurance Company______________________________ **Phone Number**____________________

Subscriber's Identification Number______________________________ **Group Number**____________________

Subscriber's Name______________________________ **Relationship to Patient**____________________

Subscriber's Social Security Number ______________________________ **Date of Birth**____________________

RELEASE OF INFORMATION:

I authorize ABT, Inc. to obtain/release/exchange information with my Primary Care Physician (PCP), other healthcare practitioners, or as requested by my insurance company for the purpose of service coordination and continuity of care.

Primary Care Physician's/Other practitioner's name ____

Address ____

____

Phone ____________________ **Fax** ____________________

❒ **Check here if you do not authorize this release of information.**

____
(Signature of Patient or Responsible Party) **(Date)**

For Office Use Only:

Chart# ________________

❒ ABT *❒ Medisoft*
Initials ____________

Associates in Brief Therapy, Inc.
Serving Southwest Virginia

Communication Between You and ABT, Inc.

Occasionally it will be necessary for our office to contact you regarding matters about counseling. This permission form will help us know when and how to contact you in ways which are comfortable for you.

By giving permission for us to contact you in one or more of the ways listed below, you are agreeing for us to leave messages and information. We will always try to be discreet in any messages we leave, but we cannot guarantee confidentiality once the message is left.

Which is your **preferred contact phone number**? (circle one) Home Work Cell

Home

Yes No May we contact you at your home telephone number? # ______________________________

Work

Yes No May we contact you at your work telephone number? # _______________________________

Cell Phone

Yes No May we contact you at your cell telephone number? # ________________________________

Courtesy Appointment Reminders

IMPORTANT: (*We are no longer making phone call reminders*)

Would you like us to remind you of your appointment via e-mail, text messaging or both? *Yes*____ *No*____

E-Mail Yes No *If you choose this option, E-mail reminders are sent (2) two business days before your scheduled appointment.*

E-Mail Address:____

Text Messaging Yes No Cell Phone Carrier_____________________ Cell Phone ( )_________________

Choose how often you would like a text message: **(You cannot respond back to a text message)**

- ○ 48 hours
- ○ 24 hours
- ○ 2 hours
- ○ 48 & 24 hours
- ○ 48 & 2 hours
- ○ 48, 24 & 2 hours

NOTE: If you need to make/change/cancel an appointment, have patient account or insurance questions, please CALL our office at 540-772-8043.

Patient Health Questionnaire & Intake – Child / Adolescent

Fill out as much as possible before the initial session.
Your counselor will discuss this questionnaire with you at that time.

Child's Name: ____ Today's Date: ______________

Current custody status: ☐ Parent(s) ☐ Sole Parental Custody ☐ Joint Legal Custody
☐ DSS Custody ☐ Shared Custody ☐ Other: ________________

List all persons who may bring this child to therapy sessions:

Name: ____ Relationship: __________________

Name: ____ Relationship: __________________

Name: ____ Relationship: __________________

Household Information

Client's current living situation:
☐ At home with parent(s) /guardian ☐ Foster Care ☐ Other __________________
☐ With other family ☐ Residential Placement

Please list all members of the household:

Name	*Relationship to Patient*

Please list any other significant family members who do not live with client:

Name	*Relationship to Patient*

School Information

School Name: ____

Teacher Name(s): ____

Grade Level (circle one): K 1 2 3 4 5 6 7 8 9 10 11 12

Academic Performance: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Failing
Behavior in school: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Failing

IEP in place? ☐ No ☐ Yes (explain): ____

Social / Family Information

What activities does your child enjoy?

☐ Phone (talking/texting)	☐ Sports	☐ Video Games	☐ Playing with Toys
☐ Reading	☐ Shopping	☐ TV / Movies	☐ Being with Friends
☐ Art / Crafts	☐ Playing Outside	☐ Internet / Computer	☐ Other: __________

Normal Bedtime: ________ Number of hours usually slept: ________

Where does your child sleep? ____

What is your child's diet like? ____

How is your child usually disciplined? ____

The household is usually: (check all that apply)

☐ Quiet	☐ Calm	☐ Lots of Conflict	☐ Highly Structured
☐ Noisy	☐ Active /Busy	☐ Tense	☐ More relaxed /unstructured

Religious preference: ____

Involved in a worship center? ☐ No ☐ Yes ______________________________________

Is there anything else you would like for us to know about your child's home life? ___________________

____

Developmental History

Was your child:

☐ Planned	☐ Breast Fed	☐ In Day Care
☐ Unplanned	☐ Bottle Fed	☐ Kept at Home

☐ Exposed to medications /drugs /alcohol in the womb
☐ Difficulty or high-risk pregnancy or delivery

At what age did your child: Talk_______ Walk______ Potty Train______

Describe any developmental delays: ____

____

Medical History

Primary Care Physician: ____

Has your child experienced any of the following?

☐ Allergies (food, drug, substances) Please explain: _________________________
☐ Childhood Trauma ______________________________________
☐ Chronic medical problems ______________________________________
☐ Severe illness, injury, surgery ______________________________________
☐ Significant family medical history ______________________________________
☐ Significant family mental health history ______________________________________
☐ Prior mental health diagnosis ______________________________________
☐ Prior developmental diagnosis ______________________________________

Current Medication	*Dosage*

Treatment History

Please list all mental health treatment or hospitalizations

Facility / Therapist	*Purpose*	*Date*

Response to Treatment: ____

Other agency services /relationships in the last six months:

☐ Occupational Therapy ☐ Justice System ☐ Other: ________________

☐ Speech Therapy ☐ Child Protective Services ________________________

☐ Disability /Social Security ☐ Other DSS services

Electronic Device Screen Time

Hours per day: ☐ None ☐ 1-3 ☐ 3-6 ☐ 6+

Is there a desire to better manage screen time ☐ No ☐ Yes

Caffeine Intake (cups per day)

Coffee: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+

Tea: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+

Soda: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+

Sensitive to caffeine? ☐ No ☐ Yes ________

Substance Use History (If applicable. – If yes, please indicate amount & frequency)

☐ Alcohol ____

☐ Smoking ____

☐ Prescription drugs ____

☐ Illegal drugs ____

☐ Other: ____

Current Treatment Focus

What brings you and your child to our office today? ________________________________

____

____

What services are you seeking?

☐ Individual Therapy ☐ Psychological /Educational Testing ☐ Psychiatric Services

☐ Family Therapy ☐ Other: ____

I / we would like to address the following: (check all that apply)

☐ Child's mood or emotional state ☐ Child's behavior

☐ Child's school performance ☐ Child's sleep, eating, or physical concerns

☐ Child's cognitive/mental functioning ☐ Child's relationships with family or peers

☐ Parenting ☐ Family relationships

☐ Divorce ☐ Other: ___________________________

☐ Abuse or neglect ___________________________

Child Assessment:

Please check all that currently apply to your child and indicate past concerns with the letter "P".

☐ Anxiety
☐ Depressed mood
☐ Panic Attacks
☐ Racing thoughts or speech
☐ Obsessions / Compulsions
☐ Excessive fears or phobias
☐ Dissociative states
☐ Touchy / Irritable
☐ Nightmares
☐ Sleep problems
☐ Bedwetting or incontinence
☐ Tantrums or meltdowns
☐ Difficult to parent
☐ Conflicting parenting styles
☐ Parental marital problems
☐ Adopted or in foster care
☐ Lots of physical complaints

☐ Hurts others
☐ Lying
☐ Stealing
☐ Destroying property
☐ Defiance
☐ Blames other for mistakes
☐ Angry / Resentful
☐ Lack of conscience
☐ Bizarre behavior
☐ Clingy
☐ Separation anxiety
☐ Seems to overreact
☐ Parent feels overwhelmed
☐ Argues with adults
☐ Doesn't seem to listen
☐ Seems adult-like or older
☐ Life has been unstable

☐ Hyperactive
☐ Attention problems
☐ Worries all the time
☐ Impulsive
☐ Low self-esteem
☐ Suicidal thoughts
☐ Suicide attempts
☐ Self-harm / mutilation
☐ Sexually active / acting out
☐ Difficulty with change
☐ Needs predictability / routine
☐ Unexplainable mood shifts
☐ Running Away
☐ Deliberately annoys people
☐ Takes excessive risks
☐ Seems younger than age
☐ Life changes pending

I certify that the information provided above is correct to the best of my knowledge, and that I am authorized to provide such information on behalf of this client.

____ ______________________
Signature of Legally Responsible Person Date

____ ______________________
Signature of Therapist Completing Assessment Date

To Be Completed by Therapist: ***(Do not write in this section)***

Based on the assessment, the recommended treatment is:

☐ None
☐ Educational Services
☐ Medical / Physical
☐ Psychiatric Assessment
☐ Inpatient MH Treatment

☐ Client Declined
☐ Financial
☐ Substance Abuse Treatment
☐ Psychological Testing
☐ Outpatient MH Treatment

☐ Community Resources
☐ Legal
☐ Twelve-step Program
☐ Social Services
☐ Others: ____________

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Roanoke, VA 24018
Phone: (540) 772-8043
Fax: (540) 772-8242
www.abtcounseling.com

Main Office: Roanoke, VA
Satellite Offices: Salem, VA
Blacksburg, VA
Daleville, VA
Floyd, VA

INFORMED CONSENT

Welcome to our practice. We are pleased to have the opportunity to serve you and hope that this handout will provide helpful information in making an informed decision concerning our services. **Please ask questions at any time.**

Organization Information: Associates in Brief Therapy, Inc. (ABT, Inc.) consists of counselors who are employees and counselors who are independent contractors. The President and Clinical Director of ABT, Inc. is David L. Mortellaro, LPC, LMFT.

Hours of Operation: Our office staff, located in our Roanoke office, answers telephone calls from 8:30 a.m. until 5:30 p.m. Monday through Thursday and from 8:30 a.m. until 12:30 p.m. on Friday. At all other times calls are forwarded to a voice mail system. Therapists do not answer phone calls while they are in session. Therapists are available for appointments Monday through Friday. Evening appointments are available Monday through Thursday. Satellite office hours vary; please call our main office in Roanoke for specific appointment times.

Background & Training: All of our clinicians have earned a graduate degree (Masters or Doctorate) from an accredited university. All ABT, Inc. counselors are licensed to practice in the state of Virginia. ABT, Inc. also employs resident counselors who have completed a graduate degree and are pursuing licensure under direct supervision of a licensed clinician. The clinical supervisor's name and credentials may be obtained upon request. Our clinicians only practice within their scope of training and experience. In the course of our training and previous employment, we have had experience in treating a wide variety of individuals including children, adolescents and adults in individual, couples, family, and group counseling. **Your counselor will have his/her own primary specialty areas of expertise.**

Philosophy: We accept in our practice only clients whom we believe have the capacity to resolve their own problems with our assistance. The foundation of the healing process is the therapeutic relationship which is based on trust, respect, honesty, confidentiality and effort. As people learn more about their strengths and weaknesses, they usually become more accepting of themselves and others and feel more empowered to accomplish their goals. As the client, you are responsible for setting the goals you want to accomplish and can terminate counseling at any time. Our responsibility is to help you accomplish these goals in the shortest time possible. If counseling is successful, you should feel better about yourself and be able to face life's challenges in the future without our support or intervention. We cannot guarantee results.

We ask that you be as honest and as open as possible in discussing your concerns. If you are unclear about anything regarding your therapy, please ask questions. Psychotherapy can be very helpful for some individuals but it is not without some risks. These risks may include the experience of intense and unwanted feelings, such as sadness, anger, fear, guilt or anxiety. It is important to remember that these feelings may be natural and normal and are an important part of the therapy process. Other risks might include: recalling unpleasant life events, facing unpleasant thoughts and beliefs or possible alteration of an individual's relationships. We will make every effort to minimize potential risks and hazards which are not helpful to the therapeutic process. Often in therapy, major life decisions are made, including: decisions involving families or friends, changes in relationships, or changes in your jobs or careers. These decisions are a legitimate outcome of therapy as a result of an individual's calling into question some of their beliefs and values, recognizing their strengths, increasing their self-acceptance, alleviating symptoms and problems or learning more helpful coping skills.

We use research-based "best practices therapy methods" including, but not limited to, Cognitive-Behavioral Therapy (CBT), Solution-Focused Brief Therapy, faith-based counseling, Person Centered Therapy, Strategic or System based approaches, assessments, and bibliotherapy. These methods sometimes utilize psycho-education methods with homework assignments.

Confidentiality

I understand the confidentiality of the work I do together with my therapist is upheld at all times. However, there are certain exceptions to this rule: (1) if my counselor suspects child or elder abuse has occurred, the law requires it be reported to the authorities; (2) if my counselor believes I am a clear and imminent danger to myself or another person, the counselor must notify appropriate authorities to prevent that occurrence; (3) if it becomes necessary to contact an attorney or collection agency, then my name, identifying information about how to reach me, and amount owed becomes available to these agents; and (4) in a legal proceeding, a court may order a release of information.

Fees, Payments and Insurance: We make every effort to keep down the cost of your medical care. Therefore we require that you pay for your treatment at the time of your visit. The cost of therapy is $125.00 for the initial session and $115.00 for each follow up session. Payment may be made by cash, check or credit/debit card. If you have insurance coverage we ask that you make your co-pay and unmet deductible fees at the time of your office visit. If at any time during your treatment you are having financial difficulties and cannot make the required payments on your account, you may contact the Office Manager to set up financial arrangements. Most plans include co-payments/co-insurance, a deductible and other expenses which must be paid by the patient. If you have insurance, please bring your insurance card with you. We will automatically file your insurance for you if you have provided us with the necessary information. **However, we cannot fully guarantee your coverage or your benefits. In the event that your insurance company does not pay for services rendered, you will ultimately be responsible for payment.** If you have a change in insurance coverage or benefits, please notify the business office immediately.

Returned Checks: If you pay for any service provided with a check and that transaction is returned to us from your bank as non-payable, there will be a charge of $35.00. After a non-payment incident, checks may no longer be accepted and you will be required to pay all outstanding balances on a **cash only basis**.

Psychological Testing: Psychological testing is sometimes a critical component of evaluating problems and strengths and assisting clients in accomplishing their goals in the shortest time possible. After an initial interview your therapist may recommend such assessment. Costs for this service depend on the testing instruments used and the length of time required for administration and scoring. The exact charges will be discussed with you prior to any testing.

Cancellations: Since therapists see patients by appointment only, and each appointment constitutes a significant portion of the therapist's day, it is common practice to charge a fee for missed appointments. A charge of $25.00 will be made when less than 24-hour advance notice is given for a cancelled appointment. A charge of $45.00 will be made if you do not show up for an appointment or call in response to your absence. These charges are not reimbursable by insurance carriers. We would appreciate you notifying us at (540) 772-8043 if you will not be attending a session with as much notice as possible-preferably 48 hours or more. If you do not reach us personally, please leave a voice mail for the receptionist of your cancellation.

Messages: As you work together with your therapist, you will notice that he/she does not accept phone calls while with you. During those times and at other times during the day or evening, his/her calls are answered electronically. Messages are checked frequently during the day, and he/she will attempt to call you back as soon as possible. Usually, we can get back with you within 24 hours. If you need to speak with him/her directly during regular office hours, please leave your name and phone number on his/her voice mail. On evenings, weekends, and holidays, the messages will be received and acted upon during the next working day.

Complaints: If at any time you are dissatisfied with our services, please let your therapist know or contact our Office Manager or Clinical Director. If he/she is not able to resolve your concerns you may report your complaints to the Virginia Department of Health Professions at 1-800-533-1560. Your therapist is required to follow a Code of Ethics. If you would like to see a copy of the Code it can be found on-line at the website for the American Counseling Association at www.counseling.org.

Counseling and Financial Records: Counseling and financial records are maintained on each client for a period of seven years. Records are stored in boxed paper files in a secure central location. The records are our property but may be reviewed by a client with 30 days notice.

Noncompliance: A therapist may cancel or terminate services for noncompliance with the plan of care, failure to keep or cancel appointments, violent behavior, a threat of violence or involvement in criminal behavior.

Consultation: In keeping with generally accepted standards of practice, we may confidentially consult with other mental health professionals regarding the management of treatment. The purpose of the consultation is to assure quality care. Every effort is made to protect the identity of the clients.

Emergencies: Our office is not set up to routinely provide crisis intervention services. In case of an emergency and/or our office is closed, you may go to your local Emergency Room, call Respond at (540) 776-1100 or call CONNECT at (540) 981-8181 to reach a crises counselor.

Affiliation Relationships: Employees and independent contractors of Associates in Brief Therapy, Inc. are each wholly responsible for his/her own acts and omissions.

Copying Fees for Medical Records: We attempt to honor your request of medical records as quickly as possible. We make every effort to respond within 30 days. The charge for copying and mailing medical records is as follows:

- Handling and processing fee $10.00 per request
- Photocopying (pages 1 – 25) $ .50 per page
- Photocopying (pages over 25) $ .25 per page

This charge is billed to the organization/individual requesting the records as outlined in your authorization and **payment is due in advance of the records being released**. However, you will ultimately be responsible for any unpaid fees should that party not make payment.

Permission to Treat a Minor Child: Please note that we require written permission before we can treat any client under the age of 18:

- When parents are married, the signature of one parent is sufficient to provide treatment.
- If the parents are divorced, we require the signature of the parent having legal custody of the child.
- If the parents have joint legal custody, we may require the signature of both parents
- If the parents are separated, we may also require the signature of both parents to provide treatment.

Phone authorizations are not accepted. Parents must sign the "Informed Consent/Permission to Treat Form" in person or have it notarized with seal and signature if signed off premises. We will not provide treatment for any child who does not have the proper signed consent form(s) on file. The office staff is directed to reschedule your appointment if the form(s) is not completed.

Requests for Letters: Therapists take a great deal of time corresponding with requested individuals on the behalf of their patient. There is a charge for letters written by therapists at the request of the patient. If a legal letter is needed, a fee starting at $100.00 will be charged. The charge will vary and is based on the clinical and clerical time required to complete the letter. Insurance benefits will not cover this charge; therefore, you will be fully responsible for this cost. Payment must be received before a letter can be delivered.

Request for Forms: In most instances your therapists will complete health or treatment forms on your behalf. However, please be aware that there is a charge of $15.00 for forms to be completed by therapists at the request of the patient. In the event that the form is lengthy or complex, your therapist may request that you schedule an appointment and complete the form as part of your session. Insurance benefits will not cover this charge; therefore, you will be fully responsible for this cost. Payment must be received before a form can be delivered.

Telephone Consultations: There is usually no charge for a brief phone conversation with your provider. If you require a more lengthy discussion, a receptionist will schedule a time with your therapist by phone. Please ask your therapist to explain his/her rate for phone consultations. Insurance benefits will not cover this charge; therefore, you will be fully responsible for this cost. **We ask that you pay by credit card prior to the consult.**

Court Appearances: Therapists are occasionally needed to testify in court or provide a deposition as an expert witness for a patient regarding a legal matter. If you think you may be involved in a legal dispute or may require your therapist's testimony, please inform him/her as quickly as possible. If a judge or another party subpoenas your therapist or your medical records, we are legally required to comply. If you or your attorney subpoenas any of our therapists at ABT, Inc. to appear in court on your or your dependent's behalf, **you will be charged a fee of $500.00. Full payment is expected to be paid PRIOR to the scheduled court date**. Since our therapists have to rearrange their scheduled patients in order to appear in court for you, pre-payment is required. If the time required in court is in excess of four (4) hours (including travel time) you will be charged an additional $125.00 per hour. You will be billed for the balance due. You will be charged for our therapist's presence in court, regardless if they testify or not. If court is cancelled our office needs at least a 24 hour notice in order for you to receive reimbursement of your initial $500.00 fee. Insurance will not reimburse for these fees.

Payment of Outstanding Balances: Each month we mail billing statements for each account with outstanding balances due. **You are responsible for paying the total amount due upon receipt of the statement.**

- If we do not receive payment in full for balances due within 30 days of billing, this may result in the suspension of services.
- Outstanding balances exceeding 90 days past due will result in collection procedure. In the event that your account is forwarded to an external collection agency, all collection fees will be added to your account. In addition, finance charges of 1.5% will be added each month to accounts which are 90 days past due or a $5.00 finance charge, whichever is greater. In order to service your account if sent to collections, you may be contacted via phone or any telephone number associated with your account including wireless phone numbers, text messages (which could result in charges to you) or email.

Damages to Facility: Our office is structured in order to provide a comfortable and professional setting for you. It is our policy to hold our patients or their parents financially responsible for any damages imposed upon our building or its contents. Patients or parents will be billed in full for any cost of repairing or replacing anything which is damaged. Children/adolescents must be accompanied by a an adult at all times while in our office.

Emergencies at the Facility: In case of a medical emergency at our facility, we will contact the nearest and most appropriate medical facility to provide care.

Supervision of Children: All children 10 and under must be supervised by a parent, other adult, or responsible teenager at all times. **No child under the age of 10 should be left unsupervised in the building.**

We hope this brief introduction answers some of your questions. Please feel free to ask any additional questions you may have.
Again, we welcome you to our work together and trust that it will be mutually beneficial.

(This page intentionally left blank.)

INFORMED CONSENT Signature Page

Permission for treatment is hereby authorized to ________________________, to render treatment to ________________________________ whose relationship to me is (circle one) self, child, spouse, guardian or other ______________________________ .

___________________________________	______________________________
Signature of Client, Parent or Guardian	Date
___________________________________	______________________________
Signature of Witness or Counselor	Date

I have received a copy of this Consent Form.

___________________________________	______________________________
Signature of Client, Parent or Guardian	Date

Associates In Brief Therapy, Inc.
4346 Starkey Road, Suite 1
Roanoke, VA 24018
(540) 772-8043 (877) 895-8674 Toll-Free

Locations: Roanoke
Salem
Blacksburg
Daleville

HIPAA NOTICE OF PRIVACY PRACTICES

(Effective Date: April 14, 2003)

This privacy notice is provided on behalf of: Associates In Brief Therapy, Inc.

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law. We are required by HIPAA to provide you with this notice. This notice describes our privacy practices, legal duties and your rights concerning your Protected Information. We must follow the privacy practices described in this notice while it is in effect. This notice takes effect April 14, 2003. It will remain in effect unless and until we publish and issued a new notice.

OUR PLEDGE TO YOUR PRIVACY

We are responsible for the information that we collect about you and your privacy is important to us. We are committed to protecting the confidential nature of your medical information to the fullest extent of the law. These are designed to protect your information. We understand how important it is to protect your privacy. We will continue to make this a priority.

OUR LEGAL DUTIES

We are required by law to make sure that your Protected Information that identifies you is kept private. We are to give you this notice of your legal duties and privacy practices with respect to medical information about you and follow the terms of this notice that is currently in effect.

The HIPAA Privacy Regulations generally do not preempt state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a state, or other federal laws, rather than the HIPAA Privacy Regulation, might impose a privacy standard that we are required to follow. Where such laws are in place, we will follow more stringent state privacy laws that relate to use and disclosure of Protected Information about mental health, substance abuse, chemical dependency, etc.

DISCLOSURE AND USES OF PROTECTED INFORMATION

The following categories describe different ways that we use and disclose your Protected Information for purposes of treatment, payment and health care operations:
***For Treatment.** We may disclose your Protected Information to people outside this facility who may be involved in your treatment such as doctors, nurses, technicians, medical students or other personnel who are involved in taking care of you. We may also disclose your Protected Information to people who may be involved in your medical care such as family members, clergy or others we use to provide services that are part of your care.
***For Payment.** We may use and disclosed your Protected Information so that the treatment and services you receive at this facility may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover treatment.
***For Health Care Operations.** We may use and disclose your Protected Information for health care operations. These uses and disclosures are necessary to run this facility and make sure that all of our patients receive quality care. For example, we may use your Protected Information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of the facility's patients to decide what additional services the facility should offer, what services are not needed and whether certain treatments are effective. We may also disclose information to other health care personnel for review and learning purposes. We may also combine the medical information we have with medical information from other health care providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care without learning who the specific patients are.

OTHER USES AND DISCLOSURES OF YOUR PROTECTED INFORMATION

We must disclose your Protected Information to you with some exceptions. This will be described in the Individual Rights sections of this notice. You may give us written authorization or release of information to use or disclose your Protected Information to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosure permitted by your authorization while it was in effect. Without your written authorization, we may not use or disclose your Protected Information for any reason except as described in this notice.

The following is a description of other possible ways we may (and are permitted by law) to use and/or discuss your Protected Information without your specific authorization:
***Family and Friends.** If you are unavailable to agree, we may disclose your Protected Information to a family member, friend or other person when the situation indicates that disclosure would be in your best interest. This includes a medical emergency or disaster relief. If you are available and agree, we may disclose your Protected Information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.
***Research, Death or Organ Donation.** We may use or disclose your Protected Information for research purposes in limited circumstances specified in the HIPAA privacy regulation. We may disclose the Protected Information of a deceased person to a coroner, medical examiner, funeral director or organ procurement organization for certain purposes.

***Public Health and Safety.** We may disclose some of your Protected Information permitted by state law to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may disclose your Protected Information to a government agency that oversees the health care system or government programs or its contractors, and to public health authorities for public health purposes. We may disclose your Protected Information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

***Required by Law.** We may use or disclose your Protected Information when we are required to do so by law. For example, we must disclose your Protected Information to the U.S. Department of Health and Human Services upon request in order to determine if we are in compliance with federal privacy laws. We may disclose your protected information to comply with worker's compensation or similar laws.

***Legal Process and Proceedings.** We may disclose your Protected Information in response to a court or administrative order, subpoena, discovery request, or other lawful process. These disclosures are subject to certain administrative requirements imposed by the HIPAA privacy regulation and permitted by state law.

***Law Enforcement.** We may disclose limited information to a law enforcement official concerning the Protected Information of a suspect, fugitive, material witness, crime victim or missing person subject to certain administrative requirements approved by the HIPAA privacy regulation and permitted by state law. We may disclose the Protected Information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances specified by the HIPAA privacy regulation. We may also disclose Protected Information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

INDIVIDUAL RIGHTS

Right to Inspect and Copy.** You have the right to inspect and copy your Protected Information that may be used to make decisions about your care. Usually this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, submit your request in writing to: ***Associates In Brief Therapy, Inc., 4346 Starkey Road, Suite 1, Roanoke, VA 24018. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy. If you are denied access to medical information, you may request that the denial be reviewed.

***Right to Amend.** If you feel that your Protected Information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by our office. We are required by law to keep records for six (6) years. We may deny your request for an amendment if it is not made in writing or does not include a reason to support the request. In addition, we may deny the request to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for Associates In Brief Therapy, Inc.;
- Is not part of the information which you would be permitted to inspect or copy;
- Is accurate and complete

***Accounting of Disclosures.** You have the right to request and receive an accounting of disclosures of your Protected Information made by us. We are not required under the HIPAA regulation to provide you with an accounting of certain types of disclosures. The most significant types include:

- Any disclosures made prior to April 12, 2003
- Disclosures for treatment, payment of health care operations activities
- Disclosures to you or pursuant to your release of authorization
- Disclosures to persons involved in your care
- Disclosures for disaster relief, national security or intelligence purposes

To request an accounting of disclosures, you must send a written request to our office. The first list your request within a 12 month period will be free. For additional lists, we may charge you for the costs involved and you may choose to withdraw or modify your request at that time.

Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care, like a family member or a friend. ***We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

***Confidential Communications.** You may believe that you will be in danger if we communicate Protected Information to you or to your address of record. If so, you have the right to request that we communicate with you about your Protected Information at an alternative location or by alternative means. We will make reasonable efforts to accommodate your request if you specify an alternate address.

CONTACTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

You may also submit a written complaint to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be penalized for filing a complaint.

Signature below is acknowledgement that you have received our Notice of Privacy Practices:

Print Name:____________________________________ Signature:___________________________________

Date:____ Witness:_____________________________________

The client wanted a copy of this privacy practice (Circle one) YES NO
This signed HIPAA will remain in the patient's file; a copy may be given upon request.