Psychological Services
Expert Care in Behavioral Medicine

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
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Date:____/____/20____

CHILD FACE SHEET

Clinician KDL LBL SC TC

Consent form Signed? __Y__N

Release form Signed? __Y__N

Patient Information

First: _____ MI ____ Last: _____

Address: _____

City/town: _____ State: _____ ZIP: _____

Home Phone: (____) ____ - _____ Work: _____

SS#: ___ - ___ - ____ Date of Birth: __/__/__ Gender __M__F

Referred by: _____

Responsible Party Information

if parents are divorced or separated please provide other parent info

First: _____ MI ____ Last: _____

Address: _____

City/town: _____ State: _____ ZIP: _____

Home: (___)_____ Work: (____)_____ Cell #(____)_____

E-Mail:(for appt. confirmation)_____

SS#: ___ - ___ - ____ Date of Birth: __/__/__ Gender __M__F

Other Parent Information and Relationship

First _____ M ____ Last _____

Address: _____ City _____ Zip _____

Cell # ( ) Email:

SS#: ___ - ___ - ____ Date of Birth __/__/__ Gender __M__F

Primary Insurance Information

***required information for insurance billing**

***Name of Insurance:** _____ **Phone #** _____

Subscriber's Name _____ **ID #** _____

Address: _____ City _____ Zip _____

Home Phone: (____) ____ - _____ Work Phone: (____) _____

Insured's SS# ___ - ___ - ____ **Date of Birth:** __/__/__

Patient's relationship to insured: ____Child Other _____

Deductible _____ Co-pay Amount: _____

If prior Authorization/Pre-Cert is *required* but not obtained you could ultimately be responsible for the total balance of the charges.

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

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CHILD CONSENT TO RECEIVE TREATMENT / AUTHORIZATION FORM

Child's Name: _____ Parent/Guardian's Name: _____

Child's DOB: _____.

Relationship Status of the child's biological parents/legal guardians (check all that apply):
___ Married/Partnered ___ Single ___*Separated ___*Divorced ___ Cohabitating ___Remarried

***If separated or divorced, what is the current custodial agreement: __Joint __ Sole __Shared Parenting
Is the other parent in agreement with your taking your child to see a Psychologist? ___ Yes ___ No

Other Parent's Name: _____ Phone #: _____

***If biological parents are separated/divorced/ soon-to-be-divorced, you will be required to complete our Divorced/Soon-to-be-divorced/Separated Parent Policy Form.

If you would like us to communicate with anyone else (e.g., a family member or other physician/healthcare provider regarding your child's treatment and/or evaluation, please complete the information below.

_____ I do not wish to have this information shared with anyone at this time.

I authorize Little Psychological Services, PLLC 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 _____

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 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 HIPPA Privacy Rule.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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DIVORCED/ SOON-to-be DIVORCED/ SEPARATED PARENT POLICY

The professionals and employees of Little Psychological Services, PLLC, seek to provide a high quality of care to our clients and their families. Divorce can intrude on, or complicate, the services being provided. The following is our policy:

1. We **require** a copy of the custody agreement or order at your child's first appointment.

2. Court-related evaluations require a court order.

3. We **require** that the parent requesting treatment and/or evaluation through our office notify the other parent (birth or adoptive) that treatment is being sought. It is the responsibility of the treatment-seeking party to request consent from the other parent. If we are informed that a parent with decision-making rights does not consent to treatment, we will not continue to provide services.

4. We **ask** that both parents schedule an appointment to provide important information regarding the child and to receive periodic treatment updates. Exceptions may be made on an individual basis with legally-bound reasons being provided (e.g., potential for danger, etc...).

5. Our office does not accept responsibility for seeking payment from the non-treatment seeking parent, regardless of your arrangement. The treatment seeking parent is responsible for paying for the reimbursement from the other party, if relevant.

6. We do not agree to keep information provided by one parent from the other parent, if you share joint Legal custody. Information important to the well-being of the child will be openly shared and discussed. Step-parents may be asked to participate in evaluation and treatment, where appropriate.

I, _____(parent or legal guardian), have read the divorce policy provided. I understand the policy and agree to its terms and provisions. I provide my consent for the provider(s) to speak to my child(ren)'s other parent and related parties regarding the treatment and /or evaluation provided.

Signature Date

Signature Date

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Credit/Debit Card Guarantee of Payment

I, _____, agree that Little Psychological Services, PLLC may bill
Name (please print)
my credit card for the following:

- Any services that have not been paid by myself or my insurance carrier within sixty (60) days of billing.
- Missed appointments and appointments I have cancelled with less than 24 hours notice ($125.00 charge per the Outpatient Services Agreement)
- The original amount plus $15.00 bank fee for bounced checks, charge backs or insufficient funds
- Any work completed for me outside the normal therapy time (prorated at $125/hr)

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

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

Type of Card: (check one): ☐ Visa ☐ MasterCard ☐ Discover

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

Card Number: _____ - _____ - _____ - _____

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

Card holder's billing address:

_____

Street/apt/floor *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)

Little Psychological Services, PLLC 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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CHILD/ADOLESCENT HISTORY QUESTIONNAIRE

Name: _____ Case#: _____

Today's Date: ____/____/____ Gender: ☐Male ☐Female

Date of Birth: ____/____/____ Race/Ethnic Heritage: _____

Age: _____yrs. _____months Releases signed? ☐Yes ☐No Consent? ☐Yes ☐No

Name of person filling out this form: _____

You are the: ☐mother ☐ father ☐ g-mother ☐ g-father ☐ aunt ☐ uncle ☐ sis ☐ bro ☐other_____

A. CHIEF CONCERN(S): Referral Source: _____

1. What is the child's main problem? What events or behaviors concern you the most? (please be specific)

_____

_____

_____

_____

_____

_____

_____

2. What specific question(s) do you need answered about the child?

Does s/he have	☐ a learning disability	☐ AD/HD	☐ ADD
Is s/he	☐ psychotic	☐ depressed	☐ anxious
Does s/he need	☐ medication	☐ therapy	
Has s/he been.....	☐ sexually abused	☐ traumatized	
Why doesn't my child.....	☐ listen	☐ behave	☐ do his/her homework

Other? _____

_____

_____

B. HISTORY OF THE CURRENT PROBLEM:

1. How old was the child/adolescent when s/he started having these problems? _____yrs
2. Has the child/adolescent ever seen a doctor or therapist for this problem? ☐Yes ☐No

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

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

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

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3. Is the child taking medication(s) now? ☐Yes ☐No

Name of Medication	dosage	times per day

4. Has the child/adolescent taken other medications in the past? ☐Yes ☐No Which ones? _____

_____

5. Has the child/adolescent's treatment been helpful? ☐Yes ☐No

6. Has the child/adolescent ever been in a hospital of residential facility for a behavior or mental problem? ☐Yes ☐No

Name of Facility	Child's age	Days in Facility	Response to Treatment
			☐great ☐good ☐so-so ☐poor
			☐great ☐good ☐so-so ☐poor
			☐great ☐good ☐so-so ☐poor

C. FAMILY HISTORY

1. Who lives in the home with the child/adolescent (begin with the adults)?

Name	Age	Relationship to child/adolescent

2. Please list the names, ages, and relationships of any siblings outside the home. ☐There are no others

Name	Age	Relationship to child/adolescent
		☐Full ☐ ½ ☐Step ☐Bro ☐Sis
		☐Full ☐ ½ ☐Step ☐Bro ☐Sis
		☐Full ☐ ½ ☐Step ☐Bro ☐Sis
		☐Full ☐ ½ ☐Step ☐Bro ☐Sis

3. Are the child/adolescent's parents ☐married/partnered ☐separated (separation date_____) ☐divorced (divorce date_____)

4. What is the current custody arrangement? ☐ Sole ☐Joint ☐Shared Parenting

Number of Days with each parent _____

5. Please describe the parents' relationship ☐excellent ☐good ☐fair ☐poor ☐hostile ☐no contact

Parent #1 Information ***Is this a biological parent ☐ yes ☐ no***

1. Name_____ Age_____ Town of Residence_____
2. How far did this parent go in school? (circle) 5 6 7 8 9 10 11 12 ☐GED ☐Some College☐ College Degree _____
3. Employer_____ Occupation_____ How long there?_____
4. Does this parent 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 addiction ☐Alcohol addiction ☐ Legal History ☐ ADHD/LD ☐Other _____

5. How many brothers and sisters does this parent have:
   He/She is the _____child out of _____total.
6. Do any of the brothers or sisters of this parent have a history of ☐anxiety ☐depression ☐alcoholism ☐drug abuse ☐problems with the law ☐ bipolar ☐ AD/HD or LD ☐ other_____ ☐There is no family history of mental health problems
7. Did the parents of parent #1 separate/divorce? ☐Yes ☐No How old was parent #1? _____yrs
8. Are these grandparents involved in the child/adolescent's life? ☐Yes ☐No Town of Residence_____
9. Does either grandparent have a history of ☐anxiety ☐depression ☐bipolar disorder ☐alcoholism ☐drug abuse ☐problems with the law ☐ other_____ ☐ No history of mental health problems

Parent #2 Information ***Is this a biological parent ☐ yes ☐ no***

1. Name_____ Age_____ Town of Residence_____
2. How far did this parent go in school? (circle) 5 6 7 8 9 10 11 12 ☐GED ☐Some College☐ College Degree
3. Employer_____ 15. Occupation_____ 16. How long there?_____
4. Does the parent 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 addiction ☐Alcohol addiction ☐ Legal History ☐ ADHD/LD ☐Other _____
5. How many brothers and sisters does this parent have:
   She/He is the _____child out of _____total.
6. Do any of the siblings have a history of ☐anxiety ☐depression ☐alcoholism ☐drug abuse ☐ bipolar ☐ AD/HD or LD ☐problems with the law ☐ other_____ ☐There is no family history of mental health problems
7. Did the parents of parent #2 get divorced? ☐Yes ☐No How old was parent #2? _____yrs
8. Are the grandparents involved in the child/adolescent's life? ☐Yes ☐No Town of Residence_____
9. Does either grandparent have a history of ☐anxiety ☐depression ☐alcoholism ☐drug abuse ☐ bipolar ☐problems with the law ☐ other_____ ☐ No history of mental health problems

D. DEVELOPMENTAL/MEDICAL HISTORY

1. Was the child born: ☐Full term? ☐Premature? _____wks/mos; birth weight?_____ lbs_____ oz
2. Were there any complications during the pregnancy or birth? ☐Yes ☐No If so, what were they?_____

_____

_____

3. Did his/her birth mother do any of the following during pregnancy? ☐smoke ☐drink ☐ drugs ☐ medicines ☐none of above
4. Please describe the child/adolescent's temperament as a baby: ☐Easy ☐Difficult ☐Slow to warm up
5. Was s/he colicky as a baby? ☐Yes ☐No For how long?_____
6. Describe his/her activity level as an infant: ☐Extremely Active ☐Very Active ☐Active ☐Inactive ☐Extremely Inactive
7. Who was primarily responsible for caring for the child/adolescent as an infant? _____
8. Were there any changes or disruptions in care during the infant years? ☐change in caregiver ☐divorce ☐ separation ☐short-term separation from a parent. ☐None of the above ☐other _____
9. Did the child/adolescent's parent have: ☐depression ☐anxiety during the first 2 years? ☐Yes ☐No
10. How old was the child/adolescent when s/he first: ☐talked _____ ☐walked_____ ☐was potty trained_____ ☐was dry at night_____
11. At what age did the child/adolescent begin sleeping in his/her own bed? _____. Does s/he sleep alone now on a consistent basis? ☐Always ☐Mostly ☐Sometimes ☐Never
12. Has the child/adolescent ever had seizures? ☐Yes ☐No If so, explain _____

13. Has the child/adolescent ever been knocked unconscious from a head injury? ❑ Yes ❑No If so, explain _____

_____

14. Has the child/adolescent had any major ❑accidents ❑injuries ❑illnesses ❑diseases ❑hospitalizations? ❑None of the above
If so, please describe_____

_____

_____

15. Does the child ❑wear eye glasses or ❑need hearing aids?
16. Has the child/adolescent had problems with any of the following? ❑language ❑ stuttering ❑self-control ❑aggression ❑physical-motor delays ❑ separation anxiety ❑school phobia ❑soiling ❑wetting ❑bed wetting ❑none of the above

E. TRAUMA HISTORY

1. Has the child ever been physically beaten or abused? ❑Yes ❑No If yes, when? Age(s) _____ to _____
By whom?_____ How often?_____ Threats made? ❑Yes ❑No
2. Has the child ever had any sexual experiences or abuse? ❑Yes ❑No If yes, when? Age(s) _____ to _____
By whom?_____ How often?_____ Threats made? ❑Yes ❑No
3. Has the child/adolescent witnessed or experienced any of the following? ❑ domestic violence ❑neglect ❑divorce ❑death(s) ❑ loss of loved one(s) ❑ catastrophe or natural disaster ❑other_____

_____

4. Has the child ever had a parent abandon them? ❑Yes ❑No At what age?_____ For how long?_____
5. How many times has the child moved in his/her lifetime?_____

F. SOCIAL HISTORY/ACTIVITIES OF DAILY LIVING

1. What does your child like to do after school and on weekends? ❑Play sports ❑go to movies ❑play by self ❑read books ❑watch TV _____hrs/day ❑play video games _____hrs/day ❑ listen to music ❑ride bikes ❑play with friends ❑play with bros/sis ❑other_____
2. What is his/her favorite activity? _____
3. Does your child have chores or responsibilities at home? ❑ Yes ❑ No

Chore: _____ How well is it completed? ❑great ❑good ❑so-so ❑poor
Chore: _____ How well is it completed? ❑great ❑good ❑so-so ❑poor
Chore: _____ How well is it completed? ❑great ❑good ❑so-so ❑poor
Chore: _____ How well is it completed? ❑great ❑good ❑so-so ❑poor

4. Does the child have friends? ❑Yes ❑No Are they ❑the same age? ❑younger? ❑older?
5. How many close friends does the child/adolescent have? _____
6. Do you have any concerns about the child/adolescent's social interactions? ❑Yes ❑No What are they? _____

_____

_____

7. Does the child/adolescent have a history of aggression toward ❑peers ❑adults ❑animals ❑none of the above?
8. Does the child/adolescent ❑get teased? ❑tease others?
9. Has s/he ever had any trouble with: ❑shyness ❑making friends ❑keeping friends ❑bullying ❑being bullied?

G. LEGAL HISTORY

1. Has the child ever been: arrested? ☐Yes ☐No jailed? ☐Yes ☐No

Date	Charge	Punishment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Is this evaluation related to current legal problems? ☐Yes ☐No

H. DRUG/ALCOHOL HISTORY

1. Has the child/adolescent ever used ☐Alcohol ☐Marijuana ☐Cocaine ☐Benzodiazepines (Xanax, Valium) ☐Heroin ☐Hallucinogens (LSD/Acid) ☐Stimulants (Speed, Ritalin) ☐I/V drugs ☐Caffeine ☐Nicotine First use?_____
   Most recent use?_____ Do you suspect current use? ☐Yes ☐No Describe: _____
   _____
   _____
2. Has the child/adolescent ever received treatment for substance use? ☐Yes ☐No

I. EDUCATION HISTORY

1. Where does the child/adolescent go to school? _____
2. What grade is the child/adolescent in? ☐K ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 (☐dropped out)
3. What are his/her grades? ☐Above Average ☐Average ☐Below Average Letter grades? ☐As ☐Bs ☐Cs ☐Ds ☐Fs
4. Has s/he ever repeated a grade? ☐Yes ☐No - Which one? ☐K ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12
5. How many times has the child/adolescent changed schools? ☐None ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐>8
6. Does the child/adolescent currently receive any special education services? ☐Yes ☐No - Which ones?
   ☐Classes for Behavior disorder ☐Speech Therapy ☐Tutoring
   ☐Classes for Learning Disability ☐Resource Room Help ☐ 504 plan

81. In what grade did the child/adolescent begin Special Ed? ☐K ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12
82. Has the child/adolescent ever been: ☐suspended from school _____times ☐kicked out of school _____times?
83. Does the child get along with his/her classmates? ☐Yes ☐No – Why not?_____

****Please Stop Here - Thank You****

FOR OFFICE USE ONLY

J. MENTAL STATUS

Age_____ Congruent with Age?_____

Dress_____

Hygiene_____

Identifying features_____

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

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

_____

Speech _____

Judgment and insight_____

_____

Thought process (e.g. loose, blocked)_____

_____

Thought content (e.g. delusions)_____

Perceptual abnormalities (e.g. hallucinations)_____

_____

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

_____

Effort/Persistence – Ability to understand and follow instructions_____

_____

Test Results and Interpretation

_____

_____

_____

_____

_____

_____

Manifestations of the Mental Disorder

_____

_____

_____

_____

_____

_____

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Diagnostic Impression

Axis I_____

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Axis II_____

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Axis III_____

Axis IV_____

Axis V: Current GAF = _____

Plan_____

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KENTUCKY NOTICE FORM

Notice of 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 *"authorization"* 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.

Kirk D. Little, Psy. D & Laurie B. Little, Psy. D. – *Co-Presidents*

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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 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.

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 or Kentucky Board of Medical Licensure (502) 429-7150.

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.

KEEP FOR YOUR RECORDS

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