



Center for Family Psychiatry

A Complete Approach to Mental Health

New Patient Forms Adult Package

Please fill out completely and bring to your appointment.



“With each sunrise, we start anew.” - unknown

**Consent for the Release of Information
To Coordinate Care with Primary Physicians**

(Please attach this to the patients chart in your office- we don't need the patients chart from you)

A. PATIENT INFORMATION									
Patient Name _____									
Patient Address _____ _____									
Date of Birth _____	Telephone Number _____								
B. PROVIDER INFORMATION	C. PRIMARY PHYSICIAN INFORMATION								
_____ Center for Family Psychiatry 120 Handley Road, Suite 310 Tyrone, GA 30290 Tel: 770-486-1011 Fax: 770-486-1067	Primary Physician Name: _____ Office Address _____ Primary Physician Telephone # _____								
D. PATIENT BEHAVIORAL INFORMATION									
Date of Initial Assessment:	Diagnosis:								
Summary of Patient Evaluation:									
Current Symptoms:									
Current Medications/Treatment Plan:									
<p>The undersigned authorizes the provider and primary physician to release/obtain the following medical records and information concerning patient. The purpose of such release is to allow for coordination of care, which enhances quality, and reduces the risk of duplication of tests and medication interactions. Refusal to provide consent could impair effective coordination of care.</p> <table style="width: 100%; border: none;"><tr><td style="width: 50%;"><input type="checkbox"/> Information contained on this form</td><td style="width: 50%;"><input type="checkbox"/> Assessment/Evaluation Report</td></tr><tr><td><input type="checkbox"/> Current Medication/Treatment Plans</td><td><input type="checkbox"/> Discharge Reports/Summaries</td></tr><tr><td><input type="checkbox"/> Substance Dependence Assessments</td><td><input type="checkbox"/> Laboratory/Diagnostic Test Results</td></tr><tr><td><input type="checkbox"/> Other</td><td><input type="checkbox"/> Medical History</td></tr></table>		<input type="checkbox"/> Information contained on this form	<input type="checkbox"/> Assessment/Evaluation Report	<input type="checkbox"/> Current Medication/Treatment Plans	<input type="checkbox"/> Discharge Reports/Summaries	<input type="checkbox"/> Substance Dependence Assessments	<input type="checkbox"/> Laboratory/Diagnostic Test Results	<input type="checkbox"/> Other	<input type="checkbox"/> Medical History
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<input type="checkbox"/> Other	<input type="checkbox"/> Medical History								
This consent to release information shall expire, unless otherwise provided by state law. <input type="checkbox"/> 12 months from date of signature <input type="checkbox"/> 60 days after termination of treatment <input type="checkbox"/> other calendar date									
<u>Signature</u> of Patient/Legal Guardian	Relationship to Patient	Date							
Signature of Minor Patient	Date								
Signature of Witness	Date								

I understand that I have the right to inspect and copy the information to be disclosed. I understand that my records may be protected under the Federal Confidentiality Regulations (42CFR Part 2) and, if so, can not be disclosed without my written consent unless otherwise provided for the regulations. I understand that I may revoke this authorization at anytime, except to the extent that action has already been taken in reliance upon it, by giving written notice to the parties above.

Patient Name _____

PSYCHOSOCIAL STRESSES (Please answer in terms of the past year only.)

CIRCLE ONE

1. Have there been any recent deaths in the family? Yes / No
2. Have there been any recent divorces in the family? Yes / No
3. Have there been any recent marriages in the family? Yes / No
4. Have there been any recent births in the family? Yes / No
5. Have there been any recent conflicts with a spouse, child, parent, or near relative? Yes / No
6. Have there been any recent conflicts with a neighbor or friend? Yes / No
7. Have there been any recent deaths of neighbors or friends? Yes / No
8. Have you recently begun living alone? Yes / No
9. Have you recently retired? Yes / No
10. Have you recently moved your residence? Yes / No
11. Do you have difficulty with routine reading and writing? Yes / No
12. If in school or college, do you have academic problems? Yes / No
13. If in school or college, do you have problems with other students or teachers? Yes / No
14. Are you unemployed? Yes / No
If so, how long have you been unemployed? _____
15. Do you feel your job security is threatened? Yes / No
16. Do you feel your job is too stressful? Yes / No
17. Do you find yourself in arguments or in general discord with your supervisor or co-workers? Yes / No
18. Are you dissatisfied with your job or profession? Yes / No
19. Is your housing inadequate for you and your family? Yes / No

- | | |
|---|----------|
| 20. Is your neighborhood unsafe? | Yes / No |
| 21. Have you had difficulties with your neighbors or landlord? | Yes / No |
| 22. Do you feel your or your family's income is insufficient? | Yes / No |
| 23. Do you feel you have inadequate access to health care services? | Yes / No |
| 24. Do you feel your health insurance is inadequate? | Yes / No |
| 25. Do you have a recent history of arrest or incarceration? | Yes / No |
| 26. Are you currently or have you been recently involved in litigation regarding a civil suit, worker's compensation suit, or criminal defense? | Yes / No |
| 27. Have you recently been a victim of a crime? | Yes / No |
| 28. Have you recently been a victim of a fire, flood, tornado, hurricane or other natural disaster? | Yes / No |
| 29. Have you recently been the victim of a war, riot, assault, or other event involving physical hostilities? | Yes / No |
| 30. Have you recently had to cope with a serious medical illness or with persistent pain? | Yes / No |
| 31. Have you been a primary caretaker for a family member or friend with a serious medical illness or persistent pain? | Yes / No |

PLEASE ANSWER THE FOLLOWING:

Circle One

- | | |
|--|----------|
| 1. Have you ever heard voices repeatedly when no one was around you? | Yes / No |
| 2. Have you ever felt that others were plotting against you? | Yes / No |
| 3. Have you ever felt that you were being monitored or were under surveillance? | Yes / No |
| 4. Have you ever felt that you had special powers not experienced by others? | Yes / No |
| 5. Have you ever felt that your thoughts were being broadcast aloud? | Yes / No |
| 6. Have you ever felt that someone or something could read your mind? | Yes / No |
| 7. Have you ever felt that someone or something could control your behavior beyond your control? | Yes / No |

8. Have you ever experienced episodes of prolonged feelings of sadness, depression, or “the blues” for no reason at all? Yes / No
9. Have you ever experienced episodes of a prolonged sense of well-being, “natural high” or euphoria for no reason at all? Yes / No
10. Have you ever experienced prolonged times of feeling tense, anxious, nervous, on edge, worried, or apprehensive for no logical reason? Yes / No
11. Have you ever experienced the sudden onset of extreme anxiety or panic often with shortness of breath or heart pounding for no logical reason? Yes / No
12. Have you ever had any irrational fears, such as for heights, closed spaces, flying, driving, or public speaking that altered your lifestyle considerably? Yes / No
13. Have you ever been troubled by irrational or seemingly silly thoughts that are intrusive and seem beyond your control, and have themes such as counting, repeating certain words or phrases, fear of contamination or being infected, fear of harming a loved one, fear of embarrassing oneself, or excessive need for sameness and exactness? Yes / No
14. Have you ever felt compelled to follow certain hygiene rituals, to touch objects in a certain way, to check locks or appliances repeatedly, to check repeatedly to make certain no one has been hurt or killed, to hoard items and refuse to throw them away appropriately, or to ritualistically repeat certain behaviors over & over? Yes / No
15. Have you ever been exposed to a traumatic event in which you either experienced or witnessed the threat of death or serious injury and you persistently re-experienced the event with recurrent recollections, day-dreams or nightmares? Yes / No
16. Have you ever experienced chronic prolonged pain unrelieved by usual over-the-counter pain medications? Yes / No
17. Do you experience regularly and repeatedly:
- (a) Shortness of breath when not exerting Yes / No
 - (b) Dysmenorrhea (painful menstruation) Yes / No
 - (c) Burning pain in sex organs or rectum Yes / No
 - (d) Lump in throat Yes / No
 - (e) Amnesia (prolonged memory loss) Yes / No
 - (f) Vomiting Yes / No
 - (g) Pain in your extremities Yes / No
18. Have you ever suddenly lost your ability to see, hear, or speak, or lost the total strength of your arms or legs? Yes / No

19. Have you ever experienced prolonged periods of memory loss (not just forgetfulness or absent mindedness)? Yes / No
20. Have you ever awakened in a different geographical location and could not remember how you got there? Yes / No
21. Have you ever purchased clothes or other belongings and shortly after doing so could not remember when or from where? Yes / No
22. Have you ever felt that parts of your body were not your own? Yes / No
23. Have you ever felt that you were living in a dream or couldn't tell if what you were experiencing was a dream or reality? Yes / No
24. Have you ever felt that you could drift out of your body and look at yourself or look down on the scene you were in? Yes / No
25. Have you ever experienced repeated difficulty in sexual functioning in the areas of desire or responsiveness? Yes / No
26. Have you ever markedly restricted your food intake to control your weight, even when others said you did not have a weight problem, or said that you were too thin? Yes / No
27. Have you ever eaten huge quantities of food over a very small period of time well beyond just "overeating"? Yes / No
28. Have you ever used self-induced vomiting, laxatives or diuretics to help control your weight? Yes / No
29. Have you ever been impulsively violent, seemingly without reason? Yes / No
30. Have you ever shoplifted or stolen articles that you easily could have paid for or that you had no need for? Yes / No
31. Have you ever engaged in repeated fire setting? Yes / No
32. Have you gambled excessively with money you didn't have or couldn't afford to lose? Yes / No
33. Have you ever felt compelled to pull out your hair, particularly one strand at a time from one spot on your scalp? Yes / No
34. When in school, did you have difficulty with sitting still, daydreaming, or concentrating on assignments? Yes / No

35. Have you ever attempted suicide? Yes / No
 If so, when: _____
 If so, how: _____
36. Have you ever felt you needed to or have you attempted to cut down on your drinking? Yes / No
37. Have you ever felt annoyed by others questioning you about your drinking? Yes / No
38. Have you ever felt guilty about your drinking? Yes / No
39. Have you ever felt the need for an eye-opening drink in the morning? Yes / No
40. Have you ever been accused or abusing street drugs or prescription drugs by family, friends, or physicians? Yes / No
41. Were you the victim of sexual abuse as an adolescent or child? Yes / No
42. Were you the victim of physical or verbal abuses by your parents or parental figures? Yes / No
43. Were you ever the victim of physical abuse or beatings from a spouse or significant other? Yes / No

Past Psychiatric Treatment History

1. Have you ever been admitted to a psychiatric hospital or facility? Yes / No
 If yes, when and where: _____

2. Have you ever been admitted to an alcohol or drug treatment program, inpatient or outpatient? Yes / No
 If yes, when and where: _____

3. Have you ever received outpatient psychiatric treatment or counseling? Yes / No
 If yes, when and where _____

4. Have you ever attended AA, NA, CA, or OA? Yes / No
 If yes, when: _____

Past Medical History

1. Do you have any chronic medical illnesses? Yes / No

If yes, please list: _____

2. Are you currently taking any medications? Yes / No

If yes, please list: _____

3. Have you had major surgery in the past? Yes / No

If yes, please list: _____

4. Are you sexually active now? Yes / No
If yes, what birth control method do you use?

5. Have you ever had an HIV test? Yes / No

6. Have you ever had an adverse/allergic reaction to medications? Yes / No
If yes, please list the medication(s):

7. Do you smoke cigarettes? Yes / No
If yes, how much per day?

8. Do you drink alcoholic beverages? Yes / No
If yes, how much, how frequently?

9. Do you participate in regular aerobic exercise? Yes / No

10. When was your last physical exam? _____

- (A) Was Lab Work done? Yes / No
- (B) Was an EKG done? Yes / No

11. Overall, how would you rate your physical health?

Excellent Very Good Good Fair Poor

Family Medical/Psychiatric History

- 1. Have you had blood relatives treated by a psychiatrist, psychologist, or a counselor? Yes / No
- 2. Have you had blood relatives hospitalized for psychiatric illness? Yes / No
- 3. Have you had blood relatives who you felt had a significant psychiatric illness but never received any formal treatment? Yes / No
- 4. Have you had blood relatives treated for alcohol or drug abuse? Yes / No
- 5. Have you had blood relatives who you felt were alcohol or drug abusers but who never received any formal treatment? Yes / No
- 6. Is there a history among blood relatives of any recurrent physical illnesses? Yes / No

Social History

- 1. Did you finish high school? Yes / No
- 2. Did you finish college? Yes / No
- 3. Did you go to graduate school? Yes / No
- 4. Did you go to technical school? Yes / No

5. Are you employed? Yes / No
If yes:
(a) as what: _____
(b) where: _____
(b) for how long: _____

6. If married, is your spouse employed? Yes / No

7. Have you ever been married? Yes / No

8. Do you have children? Yes / No

If yes, how many? _____

9. Are you active in religion? Yes / No

If yes, what denominational preference? _____

10. Have you ever been arrested or convicted of a crime? Yes / No

11. Were you ever in the military? Yes / No

12. Are your parents living? Yes / No

If yes, where do they live?

Mother: _____

Father: _____

13. Did your parents stay married as long as both were alive? Yes / No

14. Do you have brothers and/or sisters? Yes / No

If yes:

Name	Age	City/State in which they live:
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT INFORMATION

Today's Date _____

Full Name _____ Title (Mr., Jr., Rev, etc) _____

Street Address: _____ Apt. # _____

City _____ State _____ Zip _____ Home Tel _____

Cell Phone _____ Other _____

SS# _____ - _____ - _____ Date of Birth ____/____/____ Sex M/ F Marital Status _____

Spouse Name _____ Spouse Date of Birth ____/____/____

Who referred you to our office?

Who is your Primary Care Physician? _____

Phone Number _____

Name and telephone # of someone to contact in case of emergency:

May we contact you at your work # to confirm or cancel appointments? Y/N

RESPONSIBLE PARTY/GUARANTOR INFORMATION

Full Name _____ Relation: _____

Street Address: _____ Apt. # _____

City _____ State _____ Zip _____ Home Tel _____

SS# _____ - _____ - _____ Employer Telephone # _____

GENERAL CONSENT FOR TREATMENT

A. CONSENT FOR TREATMENT

I, the undersigned or responsible party, jointly and severally hereby consent to treatment by Center for Family Psychiatry Inc. and all providers contracted with it, including examination, developing a treatment plan, administration of medication, and other treatment modalities as ordered by the physician or provider.

B. MISSED APPOINTMENTS

I/We understand that missed appointments are not only a loss to me, but also to the physician and other patients that could have been seen. Center for Family Psychiatry Inc. maintains a No-Show/Cancellation Policy that dictates that any appointments which are **not canceled 24 hours in advance** of the appointment time will be assessed an incremental **fee starting at \$100.00** (subject to change). If there are two No-Shows in a row or a history of No-Shows the payment for the next appointment will be taken in advance before a slot is given. **Continued No-Shows** and/or same day cancellations (usually 3 or more) **may lead to termination of relationship** or referral to another provider. The organization understands that emergencies arise and its staff will continue to do its best to accommodate everyone in an urgent situation. **The office staff does try to contact the patient on the day before the scheduled appointment as a courtesy**; however, **the client or legal guardian thereof is responsible for confirming, keeping, and scheduling appointments**. I/We understand that to respect the time of the other patients who are scheduled after Me/Us, if I/We are over **10 minutes late for my/our appointment it will have to be rescheduled** for another day and payment will be due for the missed appointment.

C. MEDICATION REFILLS

If I/We need a medication refill and it is not time for me to be seen, I/We understand that I should contact the office preferably **3-4 days prior and no less than 24 hours** before running out of medication. This will give the office staff time to obtain authorizations that may be needed and make any changes that may be required. **No medication refills** will be called in **after hours or on the weekends**. If the **physician is paged** for a medication refill there will be a **charge of \$25.00** which again is **non-payable by insurance** and will be the patient's or guarantor's responsibility.

D. TELEPHONE CONTACTS

I understand that while the organization encourages contact for emergent questions and problems, the attention to these calls requires a significant time commitment. Regardless of the reason for the call, charts must be pulled and a notation of the discussion made. The volume of 40-100 calls per week necessitates that a **nominal fee of \$30.00** be charged **for each brief telephone contact**. Extended telephone discussions will be billed on a prorated basis at a rate of **\$60.00 for each additional 10 minutes** rounded upward, to the next 10 minute interval. These fees are **non-payable by insurance** and will be entirely my responsibility.

E. EMERGENCY SITUATIONS

In the case of an emergency you can try to get in touch with your provider through the paging system- you can call the office and press the required prompts. You can also call 911 or go to your local emergency room. If you are suicidal you can call the suicide hotline at 1800-SUICIDE. If you are seeing another psychiatrist or therapist than the providers in this office please contact your therapist.

F. ASSIGNMENT OF INSURANCE BENEFITS

The undersigned shall be, jointly and severally, completely responsible for all payments for visits as well as any additional fees incurred such as No-Shows, Letters, Medical Records, telephone consultations, reports etc. Center for Family Psychiatry will not be billing any insurance(s) for any expenses incurred by the undersigned. The undersigned, and if more than one, jointly and severally, hereby authorizes payment directly to Center for Family Psychiatry Inc. or to its contracted providers otherwise payable to him/her or due to become payable to him/her, for all charges incurred during this/these office encounter(s). I/we understand that the organization does not guarantee that my insurance plan will pay and that the organization will not be attempting to get authorization for visit payments. I note that the organization is not responsible for misinformation provided by the insurance company or their representatives. **Payment will remain due and owing for services provided should either party terminate the relationship.**

G. RESPONSIBILITY OF PAYMENT

I/We understand that it is the policy of Center for Family Psychiatry and its contracted providers to not become involved in issues regarding court orders. Therefore, it is the policy of this office to treat children of divorced parents as follows:

The parent/guardian of a minor/child who brings the child in for treatment is liable for all payments and services even if the divorce decree states otherwise. However, records for a child of divorced parents will only be released to the parents having legal custody of the child; if both parent(s) have legal custody of the child; records may be released to both parties; the decision to release records rests with the providers. Appropriate fees will be charged, in advance, for the time and cost of copying such records.

It is within the discretion of the Contracted Providers of Center for Family Psychiatry as to whether any child or family for counseling services, and this includes extending therapy services for an individual child and to include family members.

Further, the patient or in the case of a minor child- the child's guardian- is responsible of payment of time expended by the Providers in response to any legal issue involving individual's therapy, including, but not limited to, responding to any attorney inquiries or subpoenas, and including any time and fees expended by the Providers for the engagement of legal representation. **Any deposition or court appearance will be billed at a minimum rate of two times the normal billing rate, with a retainer of \$1500.00** to be paid in full one week prior to the engagement. One half of the retainer will be returned for any cancellation given within 48 hours notice.

Additionally, the patient or in the case of a minor child- the child's guardian – is financially responsible for all facets of preparation and production of any requested letters, evaluations and reports. I have automatically released Center for Family Psychiatry from any obligations to me if my account goes into collections.

The patient or in the case of a minor child- the child's guardian will also be responsible for any collection/ attorney fees if this account goes into collections.

H. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

My/Our consent and authorization is hereby granted to Center for Family Psychiatry Inc. and its contracted providers, to release to healthcare facilities providing subsequent care, my insurance companies, health maintenance organizations, preferred provider organizations, medical trust fund, medical plan, my employers self-funded medical plan, third party administrators, other third party payers (which pay or may possibly pay any portion of the charges for my medical/health care) and any of their authorized agents, my confidential health and medical information, including copies of my medical records as may be requested or necessary for , including but not limited to the verification of my treatment, quality assurance/improvement functions, utilization management, discharge planning, other medical audits, or as necessary for Center for Family Psychiatry Inc. or any of my payors to comply with all applicable federal and state laws, rules and regulations, and accrediting bodies. This consent and authorization is ongoing, unless revoked by the patient in accordance with paragraph C below. I hereby release and hold harmless on behalf of myself, my heirs, executors, assigns and administrators, Center for Family Psychiatry Inc. and its contracted providers, employees and agents from any and all liability or damage occasioned by such good faith release. **I understand that I have the right to access my records, however, since Psychotherapy notes are the exception, my complete notes can be released to a third party with the consent**

of the provider I am seeing at Center for Family Psychiatry. I understand that there is a fee attached to release of my records.

I. REVOCATION OF CONSENT

I/We understand that I/We have the right to revoke this consent in writing, except to the extent that the organization and or its providers has already taken action in reliance thereon. I/We also understand that I have the right to object to the use of my health information for directory purposes and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. The organization and or its providers are not required to agree to the restrictions requested and in any event, may release records to subsequent medical providers when deemed necessary and important for the continuing care of the patient.

BY SIGNING THIS AGREEMENT PATIENT OR PATIENT’S GUARDIAN HEREBY ATTESTS THAT HE OR SHE HAS READ AND UNDERSTANDS THIS AGREEMENT.

Patient Name

Patient Signature

Date

Parent/Legal Guardian Name
(If Applicable)

Parent/Guardian Signature

Date

PATIENTS RIGHTS AND RESPONSIBILITY STATEMENT

Patients have the right to:

- Be treated with dignity and respect
- Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Their treatment and other patient information are kept private. Only where permitted by law, may records be released without member permission.
- Easily access timely care in a timely fashion.
- Know about their treatment choices. That is regardless of cost or coverage by the patients benefit plan.
- Share in developing their plan.
- Information in a language that they can understand.
- A clear explanation of their condition and treatment options.
- Information about clinical guidelines used in providing and managing care.
- Ask the provider about their work history and training.
- Give input about the members rights and responsibilities policy.
- Know about advocacy groups and community groups and prevention services.
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Receive services that will not jeopardize their employment.
- Request certain preferences in a provider.
- Have Provider decisions about their care be made without regard to financial incentives.

Statement of Patients Responsibilities

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- Ask questions about their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the provider and patient.
- Follow the agreed upon medication plan.
- Tell their providers and primary care physicians about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their providers as soon as they need to cancel their visits.
- Let the provider know when the treatment plan is not working for them.
- Let their provider know about their problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities and that I understand this information.

Patients and Guarantors signature

Date

Please feel free to ask the office staff to explain anything you do not understand. You may also obtain a copy if you wish to do so.

Office Staff
Center for Family Psychiatry Inc.

Notice of Center for Family Psychiatry Inc .and it's contracted providers Policies and Practices to Protect the Privacy of your Health Information

THIS NOTICE DESCRIBES HOW PSYCHIATRIC 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

Center for Family Psychiatry Inc. and its contracted providers may use or disclose your protected health information (henceforth termed PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- A. “PHI” refers to information in your health record that could identify you.
- B. “Treatment, Payment and Health Care Operations” refers to
 - Treatment is when Center for Family Psychiatry Inc. provides, coordinate or manage your health care and other services related to your healthcare. An example would be when we consult with another health care provider, such as your family physician or your psychologist.
 - Payment is when we obtain reimbursement for your health care. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - Health Care Operations are activities that relate to the performance and operation of 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.
- C. “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.
- D. “Disclosure” applies to activities outside my (office, clinic, practice group, etc.) such as releasing, transferring, or providing access to information about you or other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of your treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your “Psychiatric Notes”. “Psychiatric Notes” are notes we have made about our conversation during our sessions which we have kept separate from the rest of your medical records. These notes are given a greater degree of protection than PHI.

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

III. Possible Use or Disclosure of PHI or Psychotherapy Notes without Consent or Authorization

Center for Family Psychiatry Inc. and its contracted providers may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* : If we have reasonable cause to believe that a child has been abused, we must report that belief to the appropriate authority
- *Adult and domestic abuse*: If we have reasonable cause to believe that a disabled adult or elder person has had physical injury or injuries inflicted on them, other than by accidental means, or has been neglected or exploited we must report that belief to the appropriate authority.
- *Health Oversight Activities*: If we are subject of an inquiry by the Composite State Board of Medical Examiners or the Composite State Board of Professional Counselors, Social Workers and Marriage and Family Therapists, the Department of Community Health or any other Government regulatory agency with appropriate authority, we may be required to disclose your PHI or psychotherapy records.
- *Judicial and Administrative Proceedings*: If you are involved in court proceedings and a request is made about the professional services provided to you, we may provide relevant information regarding the dates and times of service. We may also provide other relevant PHI , however, psychotherapy notes, or any information that is privileged under state law, will not be released without your consent or court order. Please be advised that the privilege does not apply when you undergo an evaluation for a third party or when the valuation is court ordered; in these instances , you will be informed as to whether your records are privileged
- *Serious Threat to Health and Safety*: If we determine, or pursuant to the standards of Psychiatry should determine, that you present a serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.
- *Worker’s Compensation*: We may disclose PHI regarding you or authorized by and to the extent necessary to comply with laws relating to worker’s compensation or other similar programs, established by law, that provide benefits for work related injuries or illness without regard to fault.

IV. Patient's Rights and Psychiatrist's Duties

Patient's Rights

- *Right to Request Restrictions:* you have the right to request restrictions on certain uses and disclosures of PHI. However, we are not required to agree to a restriction 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 going to Center for Family Psychiatry Inc. and its contracted providers on your request we will send the bill to another location.)
- *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 subject to reasonable fees for copying. We may deny access to your PHI under certain circumstances, but in some cases you may have the decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend:* You have the right to request an amendment of PHI as long as PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting:* You generally have the right to receive an accounting of disclosures of PHI. On your request we will discuss with you the details of the accounting process.
- *Right to Paper Copy:* You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Psychiatrist's or Providers Duties

- We are 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.
- We reserve the right to change privacy policies and practices with respect to PHI.
- If we revise the policies and procedures we will provide you with a revised notice via our message board at the front desk.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records or have other concerns about your privacy rights, you may contact *Kalika S Bhargave who is the Privacy Officer for the practice.*

If you believe that your privacy rights have been violated and wish to file a complaint you may send your written complaint to: Attn Kalika Bhargave, Center for Family Psychiatry Inc, 120 Handley Rd, Suite 120, Tyrone, GA 30290.

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

You have specific rights under Privacy Rule. Center for Family Psychiatry Inc and its contracted providers will not retaliate against you for exercising your rights to file a complaint.

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

This notice will go into effect on April 14th 2003.

Center for Family Psychiatry Inc. and its contracted providers reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. Any revised notices will be posted at the front desk.

Print Patient Name: _____

Please Sign _____ Date _____

(Patient or legal Guardian if under 18)

Print "signature" name if different from above _____