Center for Family Psychiatry

A Complete Approach to Mental Health

# New Patient Forms
# Child Package

**Please fill out completely and bring to your appointment.**

**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** |
|---|---|
| _____<br>Center for Family Psychiatry<br>120 Handley Road, Suite 310<br>Tyrone, GA 30290<br>Tel: 770-486-1011<br>Fax: 770-486-1067 | Primary Physician Name:<br>_____<br>Office<br>Address _____<br>Primary Physician Telephone # _____ |

**D. PATIENT BEHAVIORAL INFORMATION**

| Date of Initial Assessment: | Diagnosis: |
|---|---|

Summary of Patient Evaluation:

Current Symptoms:

Current Medications/Treatment Plan:

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.

___ Information contained on this form
___ Current Medication/Treatment Plans
___ Substance Dependence Assessments
___ Other
___ Assessment/Evaluation Report
___ Discharge Reports/Summaries
___ Laboratory/Diagnostic Test Results
___ Medical History

This consent to release information shall expire, unless otherwise provided by state law.
___ 12 months from date of signature ___ 60 days after termination of treatment ___ other calendar date

Signature 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.

# CHILD DEVELOPMENT QUESTIONNAIRE

Child's Name _____ Age: ____ Today's Date __/__/__

Address: _____ City: _____

State: _____ Zip: _____ How long at this address? _____

Child's Gender: _____ Birthdate: ___/___/___

Person Completing this Form: _____ Relation to Child:_____

Mother's Name: _____ Age: ___ Education: _____

Employer: _____Work Phone: _____

Type of Work: _____ Home Phone: _____

Father's Name: _____ Age: ___ Education: _____

Employer: _____ Work Phone: _____

Type of Work: _____ Home Phone: _____

Who referred the child to our office?

Name: _____ Address: _____

Phone Humber: _____

Who is the Child's Pediatrician/Primary Care Provider?

Name: _____ Address: _____

Phone Number: _____

**Demographics**

Child's Primary Residence: Both Parents ___ Mother ___ Father ___ Other _____

Are the Child's Parents currently:

Married? _____ Divorced? _____ Separated? _____
Other circumstances (please explain) _____
In the case of divorce/separation, what are the Custody arrangements? _____

Siblings:

Name _____ Age ____ Name _____ Age ___

Name _____ Age ____ Name _____ Age ___

Name _____ Age ____ Name _____ Age ___

Other relatives or persons living in the home: _____

Is the Child adopted? Yes _____ No _____

If Yes, please describe the circumstances: _____

_____

**School Information**

Name of School: _____ Phone: _____

Teacher's Name _____ Grade: _____

Type of School: Public _____ Private _____ Special _____

Grades repeated: _____ Grades skipped: _____

Expelled? NO _____ If YES, # of times? _____

Any known Learning Disabilities? No _____ Yes _____ If Yes, please explain:

_____

If needed, may we have permission to contact the school? No _____ Yes _____

If Yes, Signature _____-Date ____/____/_____

Is the Child in any Special Programs (speech, reading, etc.)? No ____ Yes ____ If Yes,

Explain: _____

_____

How does the school describe the Child's performance? _____

_____

What does the Child do best in at school?

_____

_____

Which of the following problems, if any, does the Child have in school?

| | | |
|---|---|---|
| _____Does not do homework | ____Does not finish homework | ___Poor Handwriting |
| _____ Poor Spelling | ____ Messy and Disorganized | ___ Poor Math |
| _____ Poor Reading Skills | ____ Forgets Assignments | ___ Poor Attention |
| _____ Does not remain seated | ____ Incomplete class work | ___ Distracted |
| _____ Oppositional in class | ____ Talks out inappropriately | ___ Test Anxiety |
| _____ Makes careless errors | ____ Excessive time to complete assignments | |

Interactions with Peers: No friends _____ Few friends _____ Many friends _____
Loses friends _____ Trouble making new friends _____

Further comments on homework, academic functions, peer relations: _____

_____

_____

**Family Medical History**

Do medical illnesses run in the family (seizures, thyroid problems, allergies, etc.)? No☐ Yes☐

If Yes, please explain: _____

_____

_____

**Family Psychiatric History**

(Please note: Depression, Bipolar Disorder, Attention Deficit, Obsessive-Compulsive Disorder, Tic Disorder, Anxiety Disorders, Schizophrenia, Substance Abuse, Suicide Attempts, and other Psychiatric problems)

Has the Child's mother or maternal relatives had similar or other psychiatric problems? _____

_____

_____

Has the Child's father or paternal relatives had similar or other psychiatric problems? _____

_____

_____

Does the Child's brother(s) or sister(s) have any psychiatric problems? _____

_____

_____

Check any that apply to this pregnancy:

_____ Anemia
_____ Toxemia
_____ Kidney Disease
_____ Measles
_____ Flu
_____ Other virus
_____ Emotional problems
_____ Threatened Miscarriage
_____ Smoked during Pregnancy
_____ Alcohol use during pregnancy
_____ Elevated Blood Pressure
_____ Swollen Ankles
_____ Bleeding
_____ German Measles
_____ Strep Throat
_____ Other Illness

**Birth History**

While pregnant with this child, was the mother under a doctor's care? No ___ Yes ☐

Was the mother given medication? No ____ Yes ____

Was the mother under anesthesia during childbirth? No ____ Yes ____ Do not know ____

If Yes: Local _____ Epidural _____ General _____
How many hours from first contraction to delivery? _____

Birth Weight: _____lbs. _____oz.

**Developmental History**

| | |
|---|---|
| Motor development (sitting, crawling, walking) | Average ___ Fast ___ Slow ___ |
| Speech and Language | Average ___ Fast ___ Slow ___ |
| Bladder Trained | Average ___ Fast ___ Slow ___ |
| Bowel Trained | Average ___ Fast ___ Slow ___ |
| Handedness | Right ___ Left ____ Both _____ |

**Medical History**

Has the Child had any of the following?

| | | |
|---|---|---|
| ____ Measles | _____ German Measles | _____ Mumps |
| ____ Chicken Pox | _____ Whooping Cough | _____ Diphtheria |
| _____ Strep Throat | _____ Meningitis | _____ Encephalitis |
| _____ Hay Fever | _____ Abscessed ears | _____ Tubes in ears |
| _____ Asthma | _____ Seizures/Convulsions | _____ Head Trauma |
| _____ Hearing deficits | _____Vision Problems | _____ other illnesses |

Has the Child had any prior surgeries? _____

_____

Does the Child take any medications currently? _____

_____

Does the child have any allergies to medicines? _____

When was the Child's last physical exam? _____
Was lab work done? No _____ Yes _____
Was an EKG done? No _____ Yes _____
Overall how would you rate the Child's physical health? _____

Is there anything else you would like us to know about the Child before we meet together?
_____

_____

_____

**Prior Treatment History**

Has the Child ever been prescribed psychiatric medications? No _____ Yes _____

If Yes, please list names and responses: _____

_____

_____

_____

Has the Child ever received mental health therapy or counseling? No _____ Yes _____

If Yes, please list names and dates: _____

_____

_____

Has the Child ever been a (known or suspected) victim of physical/verbal abuse?
No _____ Yes _____ If Yes, please explain: _____

_____

_____

Has the Child ever been a (known or suspected) victim of sexual abuse? No _____
Yes _____ If Yes, please explain: _____

_____

_____ _____
Signature of Parent/Guardian Date

Edited 04/27/07

**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 #_____

Center for Family Psychiatry
A Complete Approach to Mental Health

# 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.EMERGENY 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 it's 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 it's 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.
- Heath 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 that 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 _____