HIPAA Notice of Privacy Practices

COMPREHENSIVE BEHAVIORAL HEALTHCARE

227 West Main Road • Middletown, RI 02842 • 594 East Road • Tiverton, RI 02878 • www.FamilyTherapy.Today
Direct Line - 401-239-8928 • Alternate - 401-847-1082 • Fax - 401-847-1047

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Dr. Denise A. Nadeau, PsyD, MFT **401-239-8928**

HIPAA COMPLIANCE OFFICER Phone email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

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Please note that by signing the Acknowledgment form, you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Print Name: _____ Signature: _____ Date: _____

CBH
COMPREHENSIVE BEHAVIORAL HEALTHCARE
Individual & Family Counseling • Couples Counseling
Equestrian Therapy • Neurofeedback • Mediation
www.FamilyTherapy.Today

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CLIENT INTAKE FORM

Date: _____

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL HEALTH CARE INFORMATION

Date:_____ Time:_____ Phone Number:_____

Name of Patient_____ Date of Birth:_____

I hereby authorize Diane King to _____ Obtain from or _____ Release to (check one)

_____

(Name of Person/Place/Institution)

_____

(Address)

The following confidential health care information about:_____

Hospitalization and/or outpatient examination/treatment:

_____

(Dates of treatment and/or specific information requested)

for the purpose(s) of:_____

(Reason for request, Le, how is information to be used)

Please Check One: I hereby: _____ Consent _____ Refuse

to the release of confidential information concerning mental illness, alcohol and/or drug use, sexual abuse, venereal disease, AIDS or HIV test results.

I understand that my records are protected under the Federal Confidentiality Regulations and under the General Laws Of Rhode Island, and cannot be disclosed without my written consent except as otherwise specifically provided by law.

Any information to be release or received that is authorized by my consent evidence by this document shall not be given, transferred or relayed in any manner to any other person, either in an individual or representative capacity, without an additional written consent.

I understand that I may withdraw this consent by giving written notification to Diane King at any time prior to the disclos or release of the information. In the absence of my prior withdrawal, this consent will expire 90 days after it is signed.

I confirm that I have read the above, fully understand it and have no further questions.

_____ _____ _____

Signature of Patient/Authorized Representative | Date | Time

_____ _____

Witness to Signature of Patient/Authorized Representative | Relationship

Comprehensive Behavioral Healthcare

227 West Main Road

Middletown, Rhode Island 02842

401-239-8928

Dr. Denise Nadeau, PsyD, MFT

Psychotherapist

License # MFT00061

Informed Consent

Your Rights as a Client:

1. You have the right to ask questions about procedures used during therapy. At any time during therapy, I will, if you wish, explain my usual approach and methods with you.

2. You have the right to decide not to receive treatment assistance from me, and if you wish I will provide you with the names of other qualified professionals whose services you might prefer.

3. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued.

4. You have the right to review your records at any time.

5. One of your most important rights involves confidentiality; within certain limits, information revealed by you during the therapy will be kept strictly confidential and will not be revealed to any other person or agency without your permission.

6. Upon your written request, any part of your record files can be released to any person or agency you designate. I will tell you at the time whether or not I think releasing the information in question to to that person or agency might be harmful in any way to you.

Informed Consent (continued)

7. There are certain situations in which I am required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, I am not required to inform you of my actions in this regard. These situations are as follows:
   a) If you threaten grave bodily harm or death to another person, I am required by law to inform the intended victim and appropriate law enforcement agencies.
   b) If you threaten suicide and there is a clear and present danger that you will harm yourself, I am required to contact the appropriate authorities.
   c) If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in the subpoena.
   d) If you reveal information relative to child abuse and neglect or elder abuse, I am required to report this to the appropriate law enforcement agency.
   e) If you are in therapy by order of a court of law, the results of the treatment ordered must be revealed to the court.

The Therapeutic Process

One major benefit that may be gained from participating in therapy includes a better ability to handle or cope with marital, family, and other interpersonal relationships. Another possible benefit may be greater understanding of personal goals or values. Other benefits relate to the probable outcomes resulting from resolving specific concerns brought to therapy.

In working to achieve these potential benefits, however, therapy requires that you make changes and this may involve experiencing of significant discomfort. Remembering and therapeutically resolving unpleasant events can arouse intense feelings of fear, anger, depression, frustration, and the like. Seeking to resolve issues between family members, marital partners, and other persons can similarly lead to discomfort as well as relationship changes that may not be originally intended.

Fees and Length of Therapy

1. I agree to enter into therapy with Dr. Denise A. Nadeau, PsyD, MFT – Psychotherapist.

2. I understand that I can leave therapy at any time, and that I have no moral, legal, or financial obligation to complete any particular number of sessions.

Fees and Length of Therapy (continued)

3. Except for unforeseeable emergencies, I understand I will pay for the entire session unless I cancel 24 hours ahead of time. I further understand that it is my responsibility to consult my insurance provider to make sure therapy services are covered. If my insurance refuses to cover third party payment, I will pay the full cost of the session(s).

4. I understand that I can leave therapy at any time and that I have no moral, legal, or financial obligation to complete a maximum number of sessions. I am contracting only to pay for completed sessions.

5. I agree to pay a fee of 109.00 for the initial consultation, and to pay 77.00 for each individual session. Therapy sessions are 45 minutes long. Telephone therapy sessions are prorated at the rate of 125.00$ with a fifteen minute minimum.

I understand that Dr. Denise A. Nadeau, PsyD, MFT has made no specific promises to me about the results of treatment, the effectiveness of the procedures used, or the number of sessions necessary for therapy to be effective. I have read, or have had read to me, the issues and points in this agreement. I have discussed those points I did not understand and have had my questions answered, if any, fully answered. I hereby agree to enter into therapy with Dr. Denise A. Nadeau, PsyD, MFT and to fully cooperate to the best of my ability, as shown by my signature below.

Client(s):

X _____

_____

Therapist

_____

Date: _____

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CLIENT INTAKE FORM

Date: _____

The information requested in this form will be kept confidential.

GENERAL INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: ____

Birth Date: ____/____/_____ Age: ___ Gender: □ Male □ Female □ Other Social Security #_____-____-_____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Employer: _____ Profession/Vocation: _____

Religious Denomination/Spiritual preference: _____

Home Phone: _____ May I leave a message? □ Yes □ No

Cell/Other Phone: _____ May I leave a message? □ Yes □ No

E-mail: _____ May I email you? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication. To authorize email communication, please complete the "Consent to Correspond Electronically" Form.

Emergency Contact: _____ Telephone: _____

Relationship to you: _____

Marital Status: □ Single □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: _____

_____

Referred by: _____

May we thank this person? □ Yes □ No

If so, please give contact information: _____

INSURANCE INFORMATION (if applicable):

Are you using insurance benefits? □ Y □ N

Are you: □ Primary Policyholder □ Dependent Relationship to Policyholder: _____

Insurance Company Name: _____

Street Address: _____ City: _____ State: ___ Zip:_____

Insurance ID #_____ Group #_____

Policy Holder's Name: _____ Policy Holder's Birth Date: _____/_____/_____

Policyholder's SSN #: _____-____-_____ Policyholder's Employer: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

How would you rate your current physical health? (Please Circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

_____

_____

How would you rate your current sleeping habits? (Please Circle)
Poor Unsatisfactory Satisfactory Good Very good

How many times per week do you generally exercise? _____

Please list any difficulties you experience with your appetite or eating patterns:

_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ No □ Yes
Please list: _____

_____

Have you ever been prescribed psychiatric medication? □ No □ Yes
Please list and provide dates: _____

_____

Are you currently experiencing overwhelming sadness, grief, or depression? □ No □ Yes
If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? _____

Do you drink alcohol more than once a week? □ No □ Yes If yes, how often? _____
Do you currently use tobacco products? □ No □ Yes
How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? Bad 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 --- 10 Good

PLEASE CHECK ALL THAT APPLY & CIRCLE THE MAIN PROBLEM:

Difficulty with:	now	past	Difficulty with:	now	past	Difficulty with:	now	past
Anxiety →			People in General →			Nausea →		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Problems			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills or Hot Flashes		

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following.
If yes, please indicate yourself and/or the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

History of:		Yourself / Family Member Relationship:
Alcohol/Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obesity	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Sexual Abuse	yes / no	_____
Suicide Attempts	yes / no	_____

COUNSELING CONCERNS:

What significant life changes or stressful events have you experienced recently?

Please describe the concerns that bring you to counseling at this time:

Please share what you hope to accomplish or gain through counseling:

Comprehensive Behavioral Healthcare-Policy and Procedures

Psychiatry/medication dispensing is provided for established psychotherapy patients.

Patients who have established psychotherapists are encouraged to locate medication management through these providers and if none is ascertained, CBH will provide a list of referrals.

Psychotherapy patients who are not already patients of CBH and are wishing to pursue psychotherapy with CBH may be seen bi-weekly, weekly, bi-monthly, monthly or quarterly with a minimum of two times per year.

It is the responsibility of the patient to create and appointment time with the front office for all of the above services. Should a patient fail to schedule their appointments with the office, they will automatically be assigned and appointment times. CBH will send out reminders in advance of the scheduled appointment; however it is ultimately the responsibility of the patient to track and attend scheduled appointments. Failure to show will result in a no show or late cancellation fee.

Co payments associated with these sessions will be determined by each individual insurance policy at the time of the services is provided.

Test may be ordered by the psychiatrist and if so, must be completed during the initial assessment phase of therapy.

No show and cancellations with less than 48 hrs and 72 hrs on the weekend will be charged a cancellation fee of **$50.00** for all neuropsych testing appointments. Cancellation and/or no show of therapy and/or psychiatry appointments without 24 hr notice will be charged a **$35.00** fee.

A 30 day termination letter may be provided to patients who cancel/no show after 3 failures of participated under the policies of CBH.

Policies associated with medication management:

The psychiatrist is available mostly on Wednesdays two times per month. If you need a medication filled before your next scheduled appointment, you may request the medication be filled by your pharmacist through the computer at your pharmacy. Should the pharmacist be unable to fill the medication for any reason you may text **401-239-8928** with your name, your pharmacy and location, your medication and its milligrams. Do not request refills early, 2 to 3 days are appropriate for the request. Please do not wait until the last minute for refill, please allow 24-48 hrs for fill.

Failure to participate in all aspects of the program may generate a 30 day notice to terminate.

Should any deficiency occur in regards to the above policies and procedures, your ability to rectify the deficiency is up to the discretion of the provider and/or the CBH practice.

I have read and understand the above. I agree to the terms and policies of the above.

_____	_____	_____
Printed Name	Signature	Date

Thank you.