Nazila Counseling Center

INTAKE INFORMATION FORM

Client's Full Name:_____Today's Date: _____

Address: _____
City:_____ State:_____ Zip Code: _____

Social Security Number (this is needed for insurance purposes only): _____
Age:_____ Birthdate:_____Email: _____

Telephone: Home:_____ Work:_____Cell: _____
Employer:_____Occupation: _____

Education Level:_____Religious Preference: _____

Who may we thank for referring you? _____

Primary Physician:_____Phone/Fax Number: _____
Emergency Contact:_____Relationship:_____Ph#: _____

Describe any major health problems you have had. _____

_____

List any medications you take on a regular basis:

Name of Medication	Dose	How Often	Reason

Client Initial: _____

Substance Use

	Yes	No	Which	How Much	How Often
Alcohol (beer, wine, liquor)					
Smoking (cigarettes, cigars)					
Recreational Drugs (e.g., Marijuana, Cocaine, Crack)					
Illicit Substances (e.g., huffing)					

Describe your reason for seeking help: _____

_____

What efforts have you made to handle the problem? _____

_____

Do you see any other person as being involved in your problem? Yes No
If so, Who?_____ Relationship: _____

How? _____

To whom have you turned for help or support? _____

How were they of assistance? _____

Who suggested you seek help? Me Doctor Spouse/Significant Other Family Member Friend

Have you received psychiatric or psychological help or counseling of any kind before? Yes No
When?_____Where?_____With whom? _____

Have you ever had suicidal thoughts? Yes No Have you ever attempted suicide? Yes No
When?_____If you attempted, how? _____

How were you rescued from your attempt? Self-rescued Accidentally found Lethality miscalculated

Please circle any of the following problems that pertain to you:

Alcohol Use, Career Choices, Concentration, Education, Headaches, Loneliness, Parenting, Shyness, Unusual Sounds

Ambition, Children, Decisions, Energy, Health, Marriage, Relaxation, Sleep, Stress

Anger/Temper, Chronic Illness, Depression/ Unhappiness, Fears, Inferiority, Memory, Self-Control, Stomach Trouble, Suicide

Divorce, Finances, Insomnia, Nervousness, Separation, Tiredness

Client Initial: _____

FOR COUPLES ONLY

Are you married? Yes No Cohabitating? Yes No Engaged? Yes No
How long?_____How long did you date before marriage/cohabitation/engagement? _____

What was it about your wife/partner that made you fall in love? _____
_____

What was it about your husband/partner that made you fall in love? _____
_____

What do you miss about your husband? _____
_____

What do you miss about your wife? _____
_____

What do you see as the main problem?

Communication Sex Finances Work Parenting In-Laws Infidelity

Addiction Illness Abuse Other: _____

What do you want to accomplish through counseling? _____
_____

Client (Both Parties Sign and Initial): _____, _____

Client (Both Parties Sign and Initial): _____, _____

Insurance Company:_____Phone Number:_____

Claims Address: _____

Policy Number:_____ Group Number: _____

Authorization Code (if required):_____ Copay: _____

IF EAP:

EAP Company:_____EAP Authorization #_____No. of visits_____

AGREEMENT FOR THERAPY

1. Therapy sessions are scheduled, as much as possible, for your convenience. Therefore, cancellations must be made at least 24 hours in advance; or you will be billed the **full private pay fee** for the session.

2. No additional appointments will be made after three consecutive no-shows or five consecutive late cancellations. **Appointments will be suspended, if your account reaches an unpaid balance of $150 or more, until the balance is paid.** We are willing, at any point, to give you a referral.

3. Therapy sessions will be 45 minutes in length unless otherwise agreed upon by you and your therapist.

4. Payment for services is due at the time they are rendered unless prior arrangements are agreed upon with your therapist. If you have insurance coverage that will apply to the cost of your therapy, your therapist will cooperate in providing any appropriate information and signatures required.

5. Hypnotherapy is generally not covered by insurance; therefore, you are responsible for payment in full. You may file with your insurance for reimbursement if you think they will cover the charge.

6. There is a $45 fee for any returned checks.

7. If we are unable to collect payment from you (or your insurance company), the bill will be forwarded to a collection agency.

By signing this form, I acknowledge that I have read, understand, and agree to the above.

Signature _____ Date _____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

OUTPATIENT SERVICES CONTRACT

Welcome to our practice. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have; so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

Counseling and Psychotherapy Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and client; and the particular problems you bring forward. Theoretically, I am an Adlerian therapist and believing in empowering clients.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow; if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with one of us. Therapy involves a large commitment of time, money, and energy; so, you should be very careful about the therapist you select. If you have any questions about our procedures, we should discuss them whenever they arise.

Meetings

Therapy sessions are scheduled, as much as possible, for your convenience. Therefore, cancellations should be made at least 24 hours in advance, or you will be billed the full [private pay] rate for the session.

Therapy sessions will be 45 minutes in length unless otherwise agreed upon by you and your therapist.

Client Initial: _____

Professional Fees

The average hourly fee for professional services is $100. Beyond our weekly appointments, we charge this amount for other professional services you may need; though, we will break down the hourly cost if we work for periods of less than one hour. Other services include, but are not limited to, report writing, telephone conversations lasting longer than 10 minutes, text messages that require more than 2 exchanges, email exchanges discussing therapeutic content, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, attending school meetings, and the time spent performing any other service you may request outside of your regularly scheduled appointment.

If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time even if we are called to testify by another party. Because of the difficulty of legal involvement, we charge $125 per hour – **with a minimum of four hours charged** - for preparation and attendance (whether in person or via telephonic testimony) at any legal proceedings. If we must attend court outside of Cobb County, you will also be responsible for travel expenses to include: mileage and per diem at the current annual rate published by the Internal Revenue Service (IRS), for business travelers, for each day of the required trip; gasoline; and airline tickets.

Billing and Payments

Payment, for services, is due at the time they are rendered unless prior arrangements are agreed upon with your therapist. If you have insurance coverage that will apply to the cost of your therapy, your therapist will cooperate in providing any appropriate information and signatures required.

If your account has not been paid for more than 45 days, and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim.

Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have any health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in order to help you receive the benefits to which you are entitled. However, you (not your insurance company) are responsible for full payment of our fees. It is very important that **you** find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can, based on our experience; and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, we will be willing to call the company on your behalf after you have made the initial call.

Client Initial: _____

Due to the rising costs of healthcare, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed healthcare" plans, such as HMOs and PPOs, often require authorization before they provide reimbursement for mental health services.

These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. After your benefits end, it will be up to you as to whether or not we continue our sessions; because at that point, you will be responsible for paying for the entire session.

You should also be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes, we have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit; if you request it. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above (unless prohibited by contract).

Hypnotherapy, equine therapy, and psychological testing (e.g., MMPI, MCMI, WAIS, BHI-2, TAT, etc.) are sometimes not covered by most insurance companies. Therefore, you are responsible for paying the session fees. You may, however, file for reimbursement from your insurance company if you think they may cover the service.

Contacting Us

We are often not immediately available by telephone. We will not answer the phone when we are in session with a client. When we are unavailable, the telephone is answered by voice mail. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform us of which times you will be available. If you are unable to reach us and feel that you can't wait for one of us to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If one of us will be unavailable for an extended time, one of the other therapists in the practice will be on call. We will provide you with that contact information, if necessary.

Dual Relationships and Social Networking

Not all dual relationships are unethical or avoidable. However, romantic or sexual involvement between therapist and client is never a part of the therapy process, nor are any other actions or dual relationship situations that might impair your counselor’s objectivity, clinical judgment, or therapeutic effectiveness or that could be exploitative in nature. In addition, your therapist will never acknowledge working therapeutically with anyone without his/her written permission. In some instances, even with your permission, your counselor will choose to preserve the integrity and privacy of your working relationship. For this reason, your counselor will not accept any invitations via social or professional networking sites from clients, nor will your counselor respond to blogs written by clients or accept online comments from clients.

Client Initial: _____

Professional Records

The laws and standards of our profession require that we keep treatment records. You are entitled to receive a copy of the records unless we believe that seeing them would be emotionally damaging; in which case, we will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. We recommend that you review them in our presence so that we can discuss the contents. We are sometimes willing to conduct a review meeting without charge. Patients will be charged an appropriate fee for any time spent in preparing information requests.

Minors

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to request an agreement from parents that they agree to give up access to your records. If they agree, we will provide them only with general information about our work together; unless we feel there is a high risk that you will seriously harm yourself or someone else. In this case, we will notify them of our concern. We'll also provide them with a summary of your treatment when it is complete. Before giving them any information, we will discuss the matter with you, if possible; and will do our best to handle any objections you may have with what we are prepared to discuss.

Confidentiality

In general, the privacy of all communications between a client and a psychotherapist are protected by law; and we can only release information about our work to others with your written permission. There are a few exceptions, however.

In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order our testimony if he/she determines that the issues demand it.

Client Initial: _____

There are some situations in which we are legally obligated to take action to protect others from harm; even if we have to reveal some information about a client's treatment. For example, if we believe that a child, elderly person, or disabled person is being abused, we must file a report with the appropriate state agency.

If we believe that a client is threatening serious bodily harm to another, we are required to take protective actions. These actions may include, but are not limited to, notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in our practice. If a similar situation occurs, we will make every effort to fully discuss it with you before taking any action.

Confidentiality and Technology

Some clients may choose to use technology in their counseling sessions. This includes but is not limited to online counseling via videoconference, telephone, email, text or chat. Due to the nature of online counseling, there is always the possibility that unauthorized persons may attempt to discover your personal information. Your counselor will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communications could not occur. Please be advised to take precautions with regard to authorized and unauthorized access to any technology used in counseling sessions. Be aware of any friends, family members, significant others or co-workers who may have access to your computer, phone or other technology used in your counseling sessions. Should a client have concerns about the safety of their email, your counselor can arrange to encrypt email communication with you.

Confidentiality and Professional Consultation

We may occasionally find it helpful to consult with each other or other professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our clients. The consultant is also legally bound to keep the information confidential. If you don't object, we will not tell you about the consultations unless we feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns you may have at our next meeting. We will be happy to discuss these issues with you if you need specific advice. However, formal legal advice may be needed because the laws governing confidentiality are quite complex; and we are not attorneys.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. Due to the new HIPPA laws and regulations, it is now necessary to have an expiration date on this contract. This contract will expire two years from the date it is signed which is indicated below.

_____ _____

Client Therapist

_____

Date

CONFIDENTIAL

NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

Nazila Counseling Center recognizes our responsibility for safeguarding the privacy of your health information. This notice provides information regarding use and disclosure of protected health information by Nazila Counseling Counseling Center and our affiliated mental health counselors. This notice also describes your rights and our obligations for using your health information and informs you about laws that provide special protections for your health information. It also explains how your protected health information is used and how, under certain circumstances, it may be disclosed.

Understanding Your Mental Health Record Information

Each time that you visit a hospital, a physician, or another health care provider, the provider makes a record of your visit. Typically, this record contains your heath history, current symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. This information, often referred to as your medical record, serves as the following:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care that you received.
- Means by which you or a third-party payer can verify that you actually received the services billed for.
- Tool in medical education.
- Source of information for public health officials charged with improving the health of the regions the serve.
- Tool to assess the appropriateness and quality of care that you received.
- Tool to improve the quality of health care and achieve better patient outcomes.

Understanding what is in your health records and how your health information is used helps you to:

- Ensure its accuracy and completeness.
- Understand who, what, where, why and how others may access your health information.
- Make informed decisions about authorizing disclosure to others.
- Better understand the health information rights detailed below.

Your rights under the Federal Privacy Standard

Although your health records are the physical property of the health care provider who completed the records, you have the following rights with regard to the information contained therein:

- Request restriction on uses and disclosures of your health information for treatment, payment, and health care operations. “Health care operations” consists of activities that are necessary to carry out the operations of the provider, such as quality assurance and peer review. The right to request restriction does not extend to uses or disclosures permitted or required under the following section of the federal privacy regulations: §164.502(a)(2)(i) (disclosures to you), § 164.510(a) (for facility directories, but note that you have the right to object to such uses), or § 164.512 (uses and disclosures not requiring a consent or an authorization). The latter uses and disclosures include for example, those required by law, such as mandatory communicable disease reporting. In those cases, you do not have a right to request restriction. The consent to use and disclose your individually identifiable health information provides the ability to request restriction. We do not, however, have to agree to the restriction, except in the

situation explained below. If we do, we will adhere to it unless you request otherwise or we give you advance notice. You may also ask us to communicate with you by alternate means, and if the method of communication is reasonable, we must grant the alternate communication request. You may request restriction or alternate communications on the consent form for treatment, payment, and health care operations. If, however, you request restriction on a disclosure to a health plan for purposes of payment or health care operations (not for treatment), we must grant the request if the health information pertains solely to an item or a service for which we have been paid in full.

- Obtain a copy of this notice of information practices. Although we have posted a copy in prominent locations throughout the facility and our website, you have a right to a hard copy upon request.
- Inspect and copy your health information upon request. Again, this right is not absolute. In certain situation, such as if access would cause harm, we can deny access. You do not have a right of access to the following:
    - Psychotherapy notes. Such notes consist of those notes that are recorded in any medium by a health care provider who is a mental health professional documenting or analyzing a conversation during a private, group, joint, or family counseling session and that are separated from the rest of your medical record.
    - Information compiled in a reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.
    - Protected health information ("PHI") that is subject to the Clinical Laboratory Improvement Amendments of 1988 ("CLIA"), 42 U.S.C. § 263a, to the extent that giving you access would be prohibited by law.
    - Information that was obtained from someone other than a health care provider under a promise of confidentiality and the requested access would be reasonably likely to reveal the source of the information.

  In other situations, we may deny you access, but if we do, we must provide you a review of our decision denying access. These "reviewable" grounds for denial include the following:
    - A licensed health care professional, such as your attending physician, has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of yourself or another person.
    - PHI makes reference to another person (other than a health care provider) and a licensed health care provider has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person.
    - The request is made by your personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that giving access to such personal representative is reasonably likely to cause substantial harm to you or another person.

  For these reviewable grounds, another licensed professional must review the decision of the provider denying access within 60 days. If we deny you access, we will explain why and what your rights are, including how to seek review. If we grant access, we will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable, cost-based fee for making copies.
- Request amendment/correction of your health information. We do not have to grant the request if the following conditions exist:
    - We did not create the record. If, as in the case of a consultation report from another provider, we did not create the record, we cannot know whether it is accurate or not. Thus, in such cases, you must seek amendment/correction from the party creating the record. If the party amends or corrects the record, we will put the corrected record into our records.
    - The records are not available to you as discussed immediately above.
    - The record is accurate and complete.

  If we deny your request for amendment/correction we will notify you why, how you can attach a statement of disagreement to your records (which re may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.
- Obtain an accounting of non-routine uses and disclosures, those other than for treatment, payment, and health care operations until a date that the federal Department of Health and Human Services will set after January 1, 2011. After that date, we will have to provide an accounting to you upon request for uses and disclosure for treatment, payment, and health care operations. We do not need to provide an accounting for the following disclosures:

- To you for disclosures of protected health information to you.
- For the facility directory or to persons involved in your care or for other notification purposes as provided in § 164.510 of the federal privacy regulations (uses and disclosures requiring an opportunity for the individual to agree or to object, including notification to family members, personal representatives, or other persons responsible for your care, or your location, general condition or death).
- For national security or intelligence purposes under § 164.512(k)(2) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
- To correctional institutions or law enforcement official under § 164.512(k)(5) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
- That occurred before April 14, 2003.

We must provide the accounting within 60 days. The accounting must include the following information:

- Date of each disclosure.
- Name and address of the organization or person who received the protected health information.
- Brief description of the information disclosed.
- Brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization or a copy of the written request for disclosure.

The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

- Revoke your consent or authorization to use or disclosure health information except to the extent that we have taken action in reliance on the consent or authorization.

Our Responsibilities under the Federal Privacy Standard

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to take the following measures:

- Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative and technical safeguards to protect the information.
- Provide you this notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.
- Abide by the terms of this notice.
- Train our personnel concerning privacy and confidentiality.
- Implement a sanction policy to discipline those who breach privacy/confidentiality or our policies with regard thereto.
- Mitigate (lessen the harm to) any breach of privacy/confidentiality.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION THAT WE MAINTAIN. IF WE CHANGE OUR INFORMATION PRACTICES, WE WILL MAIL A REVISED NOTICE TO THE ADDRES THAT YOU HAVE GIVEN US.

I have received HIPAA notification from Nazila Counseling Center Client Signature: _____

Date:_____

Client Initials: _____

FOR OFFICE ONLY: