NATIONAL CENTER FOR PSYCHOLOGICAL SERVICES, INC.
LICENSED CLINICAL PSYCHOLOGISTS

TELEPHONE: 808.542.9599
FAX: 808.638.7919
EMAIL: NCPSYCHSERVICES@GMAIL.COM

Client Information Form

Today's Date: _____

I. Identification

Your name: _____ Date of birth: _____ Age: _____

Nicknames or aliases: _____

Social Security #: _____ DBN # (Military Only): _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Employer: _____ Address (city ok): _____

Your Position: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ e-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

By which method would you prefer to receive appointment reminders? ☐Text ☐e-mail

☐Phonecall

II. Insurance Information

Insurance Company: _____ Plan Name: _____

Subscriber I.D. (the person who is the primary insurance holder) PLEASE USE SPONSORS SSN IF MILITARY:

_____

Member I.D. (if different from subscriber): _____

Group Number: _____

Subscriber Name: _____ Subscriber Date of Birth:_____

Subscriber Place of Employment:

_____

Military Only:

Benefits Number: _____ DOD I.D. Number: _____

Sponsor Name: _____ Relationship to Sponsor: _____

III. How did you hear about the National Center for Psychological Services?

☐ Insurance Company Provider Listing (please list insurer) _____

☐ Yelp Listing ☐ Google Maps Listing ❑ The Provider's Website ❑ Psychology Today Listing

☐ Referred by Someone (please complete below) ❑ Other: _____

Referred By: _____ Address (city ok):

_____

May we have your permission to thank this person for the referral? ❑ Yes ❑ No

How did this person explain how the National Center for Psychological Services might be of help to you?

_____

_____

IV. Self-Identity

Race/Ethnicity

Ethnicity/national origin: _____ Race: _____

Other related way you identify yourself and consider important:

_____

Religion/Spirituality

Current religious denomination/affiliation: _____

Religious/Spiritual Involvement: ☐ None ❑ Some/Irregular ❑ Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting are you involved with?

_____

Gender & Sexual Identity

Gender Identity (check one):

☐ Female

☐ Male

☐ Transgender (non-identification with the sex assigned at birth)

Sexual Orientation (check one):

☐ Asexual (lack of sexual interest in either men or women)

☐ Bi-Sexual (sexual interest in both men and women)

☐ Gay (sexual interest in a member of the same sex)

☐ Heterosexual (sexual interest in a member of the opposite sex)

☐ Lesbian (sexual interest in a women by women)

☐ Questioning (still exploring or unsure of sexual orientation)

V. Health Information

Emergency Contact

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

Address: _____

General Health History

Starting with your childhood and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had.

Age	Illness/Diagnosis	Treatment(s) Received	Treated By	Outcome

Please list any prior mental health treatment you received and the diagnosis, if any. Include visits to a therapist, counselor, psychiatrist, psychologist, social worker, or mental health clinic, as well as any psychiatric hospitalizations, substance abuse treatment, or other residential treatment facilities.

Age	Illness/Diagnosis	Treatment(s) Received	Treated By	Outcome

List all medications, drugs, or other substances you take or have taken in the last year including prescribed medications, over-the-counter vitamins, herbs, and others.

Medication/drug/vitamin/herb	Dosage	Taken for how long?	Prescribed and supervised by

Please list any work you have done during which you may have been exposed to toxic chemicals:

Dates	Type of Work	Types of Chemicals	Effects (Confirmed or Suspected)

Please list any allergies you have:

_____

_____

From whom do you currently receive medical care?

Clinic/doctor's name: _____ Phone: _____

Address (City is OK): _____

Are you currently seeing another mental health care provider (psychologist, psychiatrist, marriage and family therapist, counselor, social worker)?

Provider's name & title: _____ Phone: _____

Address (City is OK): _____

How long have you been under this provider's care?

_____

Reason for care: _____

Do you plan to continue care with the above provider?

_____

Please list any other physicians or mental health care providers who have treated you in the *last 5 years*:

Name of Physician or Agency	Speciality	Location (City, State)	Date of Last Visit (Month/Year)

Health Habits

1. **What kinds of physical exercise do you get?**

_____

_____

2. **How much coffee, cola, tea, or other sources of caffeine do you consume each day?**

_____

_____

3. **Do you try to restrict your eating in any way?** YES NO (Circle one)

   If yes, describe how: _____

   If yes, describe why: _____

4. **Do you have any problems getting enough sleep?** Y NO (Circle one) **Hrs. of Sleep/Night**: _____

   If yes, what problems (falling asleep, staying asleep)?

   _____

5. **Do you use tobacco?** YES NO (Circle one)

   If yes, how many cigarettes/cigars/other do you use each day?

   _____

6. **Do you drink alcohol?** YES NO (Circle one)

   If yes, how many drinks do you have each day?

   _____

7. **Do you use recreational drugs?** YES NO (Circle one)

   If yes, what drugs and how much/how often?

   _____

   _____

8. **Have you ever injected drugs?** YES NO (Circle one)

If yes, have you ever shared needles? YES NO (Circle one)

9. **Have you had an HIV test in the last year?** YES NO (Circle one)

If yes, result:

_____

Menstruation *(Women Only):*

1. At what age did you start to menstruate (get your period):

   _____

2. How regular is your period?

   _____

3. How long does your period typically last?

   _____

4. Do you experience pain with your period? If so, how severe is the pain?

   _____

5. Do you experience mood changes with your period? If so, please describe:

   _____

   _____

6. How heavy are your periods?

   _____

7. Other experiences during periods?

   _____

Menopause *(Women Only):*

1. If your menopause has started, at what age did it start? _____
2. What signs or symptoms have you had?

   _____

Please list all of pregnancies *(Women Only):*

Age at Time of Pregnancy	Outcome of Pregnancy (Miscarriage, Abortion, Delivery)	If you gave birth, were there any problems with the delivery? If so, please describe.

Are there any other medical or physical problems you are concerned about?

_____

_____

VI. Reason for Visit:

In your own words, please describe what brings you here today:

_____

_____

_____

_____

_____

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What You Should Know about Confidentiality in Therapy

I will treat what you tell me with great care. My professional ethics (that is, my profession's rules about values and moral matters) and the laws of this state prevent me from telling anyone else what you tell me unless you give me written permission. These rules and laws are the ways our society recognizes and supports the privacy of what we talk about—in other words, the "confidentiality" of therapy. But I cannot promise that everything you tell me will never be revealed to someone else. There are some times when the law requires me to tell things to others. There are also some other limits on our confidentiality. We need to discuss these, because I want you to understand clearly what I can and cannot keep confidential. You need to know about these rules now, so that you don't tell me something as a "secret" that I cannot keep secret. So please read these pages carefully and keep this copy. I am happy to answer any questions you might have.

1. When you or other persons are in physical danger, the law requires me to tell others about it. Specifically:

a) If I come to believe that you are threatening serious harm to another person, I am required to try to protect that person. I may have to tell the person and the police, or perhaps try to have you put in a hospital.
b) If you seriously threaten or act in a way that is very likely to harm yourself, I may have to seek a hospital for you, or to call on your family members or others who can help protect you. If such a situation does come up, I will fully discuss the situation with you before I do anything, unless there is a very strong reason not to.
c) In an emergency where your life or health is in danger, and I cannot get your consent, I may give another professional some information to protect your life. I will try to get your permission first, and I will discuss this with you as soon as possible afterwards.
d) If I believe or suspect that you are abusing a child, an elderly person, or a disabled per son I must file a report with a state agency. To "abuse" means to neglect, hurt, or sexually molest another person. I do not have any legal power to investigate the situation to find out all the facts. The state agency will investigate. If this might be your situation, we should discuss the legal aspects in detail before you tell me anything about these topics. You may also want to talk to your lawyer.

In any of these situations, I would reveal only the information that is needed to protect you or the other person. I would not tell everything you have told me.

2. In general, if you become involved in a court case or proceeding, you can prevent me from testifying in court about what you have told me. This is called "privilege," and it is your choice to prevent me from testifying or to allow me to do so. However, there are some situations where a judge or court may require me to testify:

a) In child custody or adoption proceedings, where your fitness as a parent is questioned or in doubt.

b) In cases where your emotional or mental condition is important information for a court's decision. SEP(cont.)

c) During a malpractice case or an investigation of me or another therapist by a professional group.

d) In a civil commitment hearing to decide if you will be admitted to or continued in a psychiatric hospital.

e) When you are seeing me for court-ordered evaluations or treatment. In this case we need to discuss confidentiality fully, because you don't have to tell me what you don't want the court to find out through my report.

f) If you were sent to me for evaluation by workers' compensation or Social Security disability, I will be sending my report to a representative of that agency, and it can contain anything that you tell me.

3. There are a few other things you must know about confidentiality and your treatment:

a) I may sometimes consult (talk) with another professional about your treatment. This other person is also required by professional ethics to keep your information confidential. Likewise, when I am out of town or unavailable, another therapist will be available to help my clients. I must give him or her some information about my clients, like you. It is anticipated that if you are working with a supervisee, they may be involved in assisting with this process.

b) I am required to keep records of your treatment, such as the notes I take when we meet. You have a right to review these records with me. If something in the record might seriously upset you, I may leave it out, but I will fully explain my reasons to you.

c) This confidentiality agreement serves to affirm the commitment to maintaining the confidentiality of patient information shared within the context of clinical supervision. In accordance with applicable laws and ethical standards, any patient information disclosed to a licensed clinical supervisor and their supervisee will be treated with the utmost care and respect for privacy.

The information shared will be limited to what is necessary for the purposes of supervision, training, and professional development. All parties involved understand the importance of safeguarding patient confidentiality and agree to uphold these standards.

It is important to note that any identifiable patient information will not be shared outside of this supervisory relationship without the explicit consent of the patient, except as required by law. All discussions will occur in a secure environment, ensuring that patient dignity and privacy are preserved at all times. Consistent with other professions offering training opportunities and professional development, such as medical and dental fields, all sessions whether in person or via Telehealth will be monitored and conducted by or with the direct supervision of at least one licensed provider. Participation via Telehealth will involve that a supervisor/s, or licensed clinician/s monitor and participate in all sessions virtually. Sessions conducted in person will either involve the physical presence of a licensed clinician/s or the virtual participation of one or more licensed providers. Although some supervisees may control much of the conversation discussed, all treatment guidelines and treatment interventions will be formulated either by the licensed clinician/s or in conjunction with a supervisee as discussed during regular supervisory meetings. The licensed provider/s participating in your session will be available and present for consultation, requested feedback, and/or guidance throughout the duration of each session, even if a supervisee is present. In circumstances requiring after hour consultation, a licensed provider may also be available to you, if requested. Additionally, all formulation of a diagnosis and record keeping will be generated by a licensed clinician and all behavioral health records that may be released will include the documentation of you as being under their direct care. As standard in our practice, a licensed clinician will additionally communicate with you in between each session to briefly discuss progress and to confirm future appointments. These conversations will also be documented and may be used in modifying your treatment plan or the interventions being used during treatment. Being that this is a group practice, you may also opt to participate in our testing opportunities, neurofeedback or other treatment modalities offered. Your participation in our various services will likely involve your interaction with multiple licensed providers. In situations like this, your testing results or general progress will be discussed among those that treat you within our clinic. Regardless of who you meet with, including a supervisee, your services will always be supervised by a licensed clinician/s, and you will always have access to their feedback and/or guidance during your appointments.

Additionally, when generating records and/or formulating a diagnosis, it is standard practice and often required that you complete diagnostic testing. This testing may require an additional referral or pre-authorization from your insurance company or individual referring provider. Although we will assist you with the process, it is your responsibility to request that authorization be generated for this testing. Due to the time often required in obtaining this approval, it is recommended that all patients request this authorization shortly after their initial intake appointment. Doing so will limit any breaks in service and assist in continuity of care. Due to this process often involving multiple providers, and as previously referenced, all parties involved in the transmission of data and/or testing results understand the importance of safeguarding patient confidentiality and agree to uphold these standards.

Unless specifically discussed and agreed to, patients who have not been seen in over 30 days may be identified as inactive or that they have terminated treatment. In such cases, all tangible hard copy documentation of your services may be relocated to one of our secure facilities, where it will remain for as long as required by law. In such cases, and after no continuity of care has been maintained, all requests for records will include a statement that your behavioral health documentation, including all diagnosis, are not a current record of your psychological functioning and that if such record or documentation is needed, it is recommend that you seek additional treatment and/or testing. This process will be discussed during your initial intake appointment, although it is your responsibility to maintain an active behavioral health record, if desired.

By participating in this process, including your potential time spent with a supervisee, all involved parties acknowledge their responsibility to protect the confidentiality of patient information and to adhere to the APA ethical guidelines and legal

requirements.

4. Here is what you need to know about confidentiality in regard to insurance and money matters:

a) If you use your health insurance to pay a part of our fees, the insurance company, the managed care organization, or perhaps your employer's benefits office will require me to provide information about your functioning in many areas of your life, your social and psychological history, and your current symptoms. I will also be required to provide a treatment plan and information on how you are doing in therapy. This information may be generated with the participation of a supervisee, so as to assist in the training portion of record keeping.

b) I usually give you my bill with any other forms needed, and ask you to send these to your insurance company to file a claim for your benefits. That way, you can see what the company will know about our therapy. It is against the law for insurers to release information about our office visits to anyone without your written permission. Although I believe the insurance company will act morally and legally, I cannot control who sees this information after it leaves our office. You cannot be required to release more information just to get payments.

c) If you have been sent to me by your employer's employee assistance program, the program's staffers may require some information. Again, I believe that they will act morally and legally, but I cannot control who sees this information at their offices. If this is your situation, let us fully discuss my agreement with your employer or the program before we talk further.

d) If your account with our clinic is unpaid and we have not arranged a payment plan, I can use legal means to get paid. The only information I will give to the court, a collection agency, or a lawyer will be your name and address, the dates we met for professional services, and the amount due to our clinic.

5. Children and families create some special confidentiality questions.

a) When I treat children under the age of about 12, I must tell their parents or guardians whatever they ask me. As children grow more able to understand and choose, they assume legal rights. For those between the ages of 12 and 18, most of the details in things they tell me will be treated as confidential. However, parents or guardians do have the right to general information, including how therapy is going. They need to be able to make well-informed decisions about therapy. I may also have to tell parents or guardians some information about other family members that I am told, especially if these others' actions put them or others in any danger.

b) In cases where I treat several members of a family (parents and children or other relatives), the confidentiality situation can become very complicated. I may have different duties toward different family members. At the start of our treatment, we must all have a clear understanding of our purposes and my role. Then we can be clear about any limits on confidentiality that may exist. In most cases, it will likely be recommended that family members seeking individual treatment, see different providers. This will decrease the likelihood of dual relationships being formed or confidentially being tested.

c) If you tell me something your spouse does not know, and not knowing this could harm him or her, I cannot promise to keep it confidential. I will work with you to decide on the best long-term way to handle situations like this.

d) If you and your spouse have a custody dispute, I will need to know about it. My professional ethics prevent me from doing both therapy and custody evaluations. In most cases, it will be recommended that those involved in litigation seek additional treatment from a court appointed therapist or a provider specializing in this process.

e) If you are seeing me for marriage counseling, you must agree at the start of treatment that if you eventually decide to divorce, you will not request my testimony for either side. The court, however, may order me to testify. Again, it will be recommended that those involved in litigation seek additional treatment from a court appointed therapist or a provider specializing in this process.

f) At the start of family treatment, we must also specify which members of the family must sign a release form for the common record I create in the therapy or therapies. (See point 7b, below.)

6. Confidentiality in group therapy is also a special situation.

In group therapy, the other members of the group are not therapists. They do not have the same ethics and laws that I have to work under. You cannot be certain that they will always keep what you say in the group confidential.

7. Finally, here are a few other points:

a) I will not record our therapy sessions on audiotape or videotape without your written permission.

b) If you want me to send information about our therapy to someone else, you must sign a "release-of-records" form. I have copies you can see, so you will know what is involved.

c) Any information that you tell me and also share outside of therapy, willingly and publicly, will not be considered protected or confidential by a court.

The laws and rules on confidentiality are complicated. Please bear in mind that I am not able to give you legal advice. If you have special or unusual concerns, and so need special advice, I strongly suggest that you talk to a lawyer to protect your interests legally and to act in your best interests.

The signatures here show that we each have read, discussed, understand, and agree to abide by the points presented above.

_____ _____

Signature of Client (or Representative/Guardian) **Date**

_____

Printed Name

_____ _____

Signature of Psychologist **Date**

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Consent to Treatment

I acknowledge that I have received and have read (or have had read to me) the introductory forms provided to me about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the provider named in the letterhead above. I understand that developing a treatment plan with this provider and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided.

I am aware that I may stop my treatment with this provider at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call/text to cancel an appointment at least 48 hours (2 days) before the time of the appointment. If I do not cancel within 48 hours of my appointment, or do not show up for my appointment, all future appointments will be removed from the NCPS schedule, and I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____
Signature of Client or Guardian/Representative Date

_____ _____
Printed Name Guardian/Representative Relationship to Client

I, the provider, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of Provider Date

❑ Copy accepted by client ❑ Copy kept by provider

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

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Notice of Privacy Practices

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.

Privacy is a very important concern for all those who come to this office. It is also complicated, because of the many federal and state laws and our professional ethics. Because the rules are so complicated, some parts of this notice are very detailed, and you probably will have to read them several times to understand them. If you have any questions, your provider will be happy to help you understand our procedures and your rights.

Contents of this notice:

A. Introduction: To our clients

This notice will tell you how we handle your medical information. It tells how we use this information here in this office, how we share it with other professionals and organizations, and how you can see it. We want you to know all of this so that you can make the best decisions for yourself and your family. If you have any questions or want to know more about anything in this notice, please ask your provider for more explanations or more details.

B. What we mean by your medical information

Each time you visit us or any doctor's office, hospital, clinic, or other health care provider, information is collected about you and your physical and mental health. It may be information about your past, present, or future health or conditions, or the tests and treatment you got from us or from others, or about payment for health care. The information we collect from you is called "PHI," which stands for "protected health information." This information goes into your medical or health care records in our office.

In this office, your PHI is likely to include these kinds of information:

- Your history: Things that happened to you as a child; your school and work experiences; your marriage and other personal history.
- Reasons you came for treatment: Your problems, complaints, symptoms, or needs.
- Diagnoses: These are the medical terms for your problems or symptoms.
- A treatment plan: This is a list of the treatments and other services that we think will best help you.
- Progress notes: Each time you come in, we write down some things about how you are doing, what we notice about you, and what you tell us.
- Records we get from others who treated you or evaluated you.
- Psychological test scores, school records, and other reports.
- Information about medications you took or are taking.
- Legal matters.
- Billing and insurance information.

There may also be other kinds of information that go into your health care records here.

We use PHI for many purposes. For example, we may use it:

- To plan your care and treatment.
- To decide how well our treatments are working for you.
- When we talk with other health care professionals who are also treating you, such as your family doctor or the professional who referred you to us.
- To show that you actually received services from us, which we billed to you or to your health insurance company.
- For teaching and training other health care professionals.
- For medical or psychological research.
- For public health officials trying to improve health care in this area of the country.
- To improve the way we do our job by measuring the results of our work.

Although your health care records in our office are our physical property, the information belongs to you. You can read your records, and if you want a copy we can make one for you (but we may charge you for the costs of copying and mailing, if you want it mailed to you). In some very rare situations, you cannot see all of what is in your records. If you find anything in your records that you think is incorrect or believe that something important is missing, you can ask us to amend (add information to) your records, although in some rare situations we don't have to agree to do that. If you want, your provider can explain more about this.

C. Privacy and the laws about privacy

We are required to tell you about privacy because of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requires us to keep your PHI private and to give you this notice about our legal duties and our privacy practices. We will obey the rules described in this notice. If we change our privacy practices, they will apply to all the PHI we keep. We will also post the new notice of privacy practices in our office where everyone can see. You or anyone else can also get a copy from your provider at any time.

D. How your protected health information can be used and shared

Except in some special circumstances, when we use your PHI in this office or disclose it to others, we share only the minimum necessary PHI needed for those other people to do their jobs. The law gives you rights to know about your PHI, to know how it is used, and to have a say in how it is shared. So we will tell you more about what we do with your information.

Mainly, we will use and disclose your PHI for routine purposes to provide for your care, and we will explain more about these below. For other uses,we must tell you about them and ask you to sign a written authorization form. However, the law also says that there are some uses and disclosures that don't need your consent or authorization.

1. Uses and disclosures with your consent

After you have read this notice, you will be asked to sign a separate consent form to allow us to use and share your PHI. In almost all cases we intend to use your PHI here or share it with other people or organizations to provide treatment to you, arrange for payment for our services, or some other business functions called "health care operations." In other words, we need information about you and your condition to provide care to you. You have to agree to let us collect the information, use it, and share it to care for you properly. Therefore, you must sign the consent form before we begin to treat you. If you do not agree and consent we cannot treat you.

a. The basic uses and disclosure: For treatment, payment, and health care operations

Next we will tell you more about how your information will be used for treatment, payment, and health care operations.

For treatment. We use your medical information to provide you with psychological treatments or services. These might include individual, family, or group therapy; psychological, educational, or vocational testing; treatment planning; or measuring the benefits of our services. We may share your PHI with others who provide treatment to you. We are likely to share your information with your personal physician. If you are being treated by a team, we can share some of your PHI with the team members, so that the services you receive will work best together. The other professionals treating you will also enter their findings, the actions they took, and their plans into your medical record, and so we all can decide what treatments work best for you and make up a treatment plan. We may refer you to other professionals or consultants for services we cannot provide. When we do this, we need to tell them things about you and your conditions. We will get back their findings and opinions, and those will go into your records here. If you receive treatment in the future from other professionals, we can also share your PHI with them. These are some examples so that you can see how we use and disclose your PHI for treatment.

For payment. We may use your information to bill you, your insurance, or others, so we can be paid for the treatments we provide to you. We may contact your insurance company to find out exactly what your insurance covers. We may have to tell them about your diagnoses, what treatments you have received, and the changes we expect in your conditions. We will need to tell them about when we met, your progress, and other similar things.

For health care operations. Using or disclosing your PHI for health care operations goes beyond our care and your payment. For example, we may use your PHI to see where we can make improvements in the care and services we provide. We may be required to supply some information to some government health agencies, so they can study disorders and treatment and make plans for services that are needed. If we do, your name and personal information will be removed from what we send.

b. Other uses and disclosures in health care

Appointment reminders. We may use and disclose your PHI to reschedule or remind you of appointments for treatment or other care. If you want us to call or write to you only at your home or your work, or you prefer some other way to reach you, we usually can arrange that. Just tell us.

Treatment alternatives. We may use and disclose your PHI to tell you about or recommend possible treatments or alternatives that may be of help to you.

Other benefits and services. We may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Research. We may use or share your PHI to do research to improve treatments—for example, comparing two treatments for the same disorder, to see which works better or faster or costs less. In all cases, your name, address, and other personal information will be removed from the information given to researchers. If they need to know who you are, we will discuss the research project with you, and we will not send any information unless you sign a special authorization form.

Business associates. We hire other businesses to do some jobs for us. In the law, they are called our "business associates." Examples include a copy service to make copies of your health records, and a billing service to figure out, print, and mail our bills. These business associates need to receive some of your PHI to do their jobs properly. To protect your privacy, they have agreed in their contract with us to safeguard your information.

2. Uses and disclosures that require your authorization
If we want to use your information for any purpose besides those described above, we need your permission on an authorization form. We don't expect to need this very often. If you do allow us to use or disclose your PHI, you can cancel that permission in writing at any time. We would then stop using or disclosing your information for that purpose. Of course, we cannot take back any information we have already disclosed or used with your permission.

3. Uses and disclosures that don't require your consent or authorization
The law lets us use and disclose some of your PHI without your consent or authorization in some cases. Here are some examples of when we might do this.

a. When required by law
There are some federal, state, or local laws that require us to disclose PHI:

- We have to report suspected child abuse. If you are involved in a lawsuit or legal proceeding, and we receive a subpoena, discovery request, or other lawful process,we may have to release some of your PHI.We will only do so after trying to tell you about the request, consulting your lawyer, or trying to get a court order to protect the information they requested.
- We have to disclose some information to the government agencies that check on us to see that we are obeying the privacy laws.

b. For law enforcement purposes
We may release medical information if asked to do so by a law enforcement official to investigate a crime or criminal.

c. For public health activities
We may disclose some of your PHI to agencies that investigate diseases or injuries.

d. Relating to decedents
We may disclose PHI to coroners, medical examiners, or funeral directors, and to organizations relating to organ, eye, or tissue donations or transplants.

e. For specific government functions
We may disclose PHI of military personnel and veterans to government benefit programs relating to eligibility and enrollment. We may disclose your PHI to workers' compensation and disability programs, to correctional facilities if you are an inmate, or to other government agencies for national security reasons.

f. To prevent a serious threat to health or safety
If we come to believe that there is a serious threat to your health or safety, or that of another person or the public, we can disclose some of your PHI. We will only do this to persons who can prevent the danger.

4. Uses and disclosures where you have an opportunity to object
We can share some information about you with your family or close others. We will only share information with those involved in your care and anyone else you choose, such as close friends or clergy. We will ask you which persons you want us to tell, and what information you want us to tell them, about your condition or treatment. You can tell us what you want, and we will honor your wishes as long as it is not against the law. If it is an emergency, and so we cannot ask if you disagree, we can share information if we believe that it is what you would have wanted and if we believe it will help you if we do share it. If we do share information, in an emergency, we will tell you as soon as we can. If you don't approve we will stop, as long as it is not against the law.

5. An accounting of disclosures we have made
When we disclose your PHI, we may keep some records of whom we sent it to, when we sent it, and what we sent. You can get an accounting (a list) of many of these disclosures.

E. Your rights concerning your health information
You can ask us to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.

You have the right to ask us to limit what we tell people involved in your care or with payment for your care, such as family members and friends. We don't have to agree to your request, but if we do agree, we will honor it except when it is against the law, or in an emergency, or when the information is necessary to treat you.

You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you. Contact your provider to arrange how to see your records. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to your provider. You must also tell us the reasons you want to make the changes.

You have the right to a copy of this notice. If we change this notice, we will post the new one in our waiting area, and you can always get a copy from your provider.

You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with your provider and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

You may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

F. If you have questions or problems
If you need more information or have questions about the privacy practices described above, please speak to your provider, whose name and telephone number are listed in the letterhead. If you have a problem with how your PHI has been handled, or if you believe your privacy rights have been violated, notify your provider. As stated above, you have the right to file a complaint with us and with the Secretary of the U.S. Department of Health and Human Services. We promise that we will not in any way limit your care here or take any actions against you if you complain. If you have any questions or problems about this notice or our health information privacy policies, please notify your provider.

The effective date of this notice is August 1, 2013.

NATIONAL CENTER FOR PSYCHOLOGICAL SERVICES, INC.
LICENSED CLINICAL PSYCHOLOGISTS

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Adult Checklist of Concerns

Name: _____ **Date:** _____

Please mark all of the items below that apply, and feel free to add any others at the bottom.

- ❑ I have no problem or concern bringing me here
- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Inferiority feelings
- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk taking
- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ❑ Memory problems
- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Nervousness, tension
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Oversensitivity to rejection
- ❑ Pain, chronic
- ❑ Panic or anxiety attacks

- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, work inhibitions, laziness
- ❑ Relationship problems (with friends, with relatives, or at work)
- ❑ School problems (see also "Career concerns ...")
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems—too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders, tension
- ❑ Suspiciousness, distrust
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion
- ❑ Threats, violence
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition

❑ Other concerns or issues: _____

_____

_____

Please look back over the concerns you have checked off. Which of them is the one that you *most* want help with?

_____

_____