Vivian C. Grout, LMHC
Psychotherapist
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FLORIDA HIPAA NOTICE FORM

NOTICE OF MENTAL HEALTH PRACTITIONER'S POLICIES & PRIVACY PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

II. Uses and Disclosures Requiring Authorization

III. Uses and Disclosures with Neither Consent nor Authorization

IV. Patient's Right and Practitioner's Duties

V. Complaints

VI. Effective Date, Restrictions and Changes to Private Policy

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I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may **use** or **disclose** your **protected health information (PHI)**, for **treatment**, **payment**, and **health care operations** purposes with your **consent**. To help clarify these terms, here are some definitions:

"PHI" refers to information in your health record that could identify you.

"Treatment, Payment and Health Care Operations"

Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another mental health practitioner.

Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

"Use" applies only to activities within my practice group, such as sharing, employing, utilizing, examining, and analyzing information that identifies you.

"Disclosure" applies to activities outside of my practice group. Such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An **"authorization"** is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operation, I will obtain an authorization from you before releasing your psychotherapy notes. **"Psychotherapy notes"** are notes that I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

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

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances.

Child Abuse: If I know or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to the Florida Department of Child and Family Services

Adult and Domestic Abuse: If I know or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such suspicion to the Central Abuse Hotline.

Health Oversight:. If a complaint is filed against your mental health practitioner with the Florida Department of Health on behalf of the Board of Psychology, the Board of Clinical Social Work, Marriage & Family Therapy & Mental Health Counseling, or Florida Board of Medicine and Nursing, the Department has the authority to subpoena confidential mental health information from me relevant to that complaint.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written\authorization of you or your legal representative, or a subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety: When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

Worker's Compensation: If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those person.

IV. Patient's Right and Practitioner's Duties

Practitioner's Rights:

Right to Request Restrictions - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen. Upon your request, I will send your bills to another location).

Right to Inspect and Copy - You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.

Right to Amend - you have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting - You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Practitioner's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

If I revise the policies and procedures, I will notify you in writing with a revised notice via mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I have made about access to your records, you may contact the Security of Department of Health & Human Services. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Private Policy

This notice is currently in effect and has been so since August 15, 2006. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHIs that the office maintains. I will provide you with a revised notice by mail.

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ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF POLICIES AND PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS DOCUMENT

The undersigned acknowledges receipt of a copy of the currently effective Notice of Mental Health Practitioner's' Policies & Privacy Practices.

A copy of this signed, dated Acknowledgement shall be as effective as the original.

____
Please print your name

____
Please sign your name

____
Date signed

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority.

____.

Thank you. If you have any questions about this form, or the attached Notice, please contact our privacy officer, Vivian Grout, LMHC.

Office Use Only As a privacy officer, I attempted to obtain the patient's (or representative's) signature on this acknowledgment but did not because:

__It was emergency treatment

__The patient refused to sign

__The patient was unable to sign because: ______________________________________

__Other (Please describe) ____

Signature of Privacy Officer ____

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CLIENT INTAKE FORM DATE: ____________________

NAME: __________________________ MALE/FEMALE_______DATE OF BIRTH___________ AGE: _____

ADDRESS:____

____

____

EMAIL ADDRESS: ____

HOME PHONE: ________________ WORK PHONE: _______________ CELL PHONE:_________________

OK TO CALL ___Yes ___No OK TO CALL ___Yes ___No OK TO CALL ___Yes ___No
leave a message ___Yes ___No leave a message ___Yes ___No leave a message ___Yes ___No

HIGHEST LEVEL OF EDUCATION ACHIEVED: ______________ CURRENTLY IN SCHOOL ___Yes ___No

EMPLOYER: ____

WHOM MAY I THANK FOR REFERRING YOU: ____

YOUR REASON FOR SEEKING COUNSELING:____

____

____

SIGNIFICANT OTHER/FAMILY INFORMATION

SIGNIFICANT OTHER'S NAME: ____ AGE: _______

NAME(S) AND AGE(S) OF CHILDREN: ___________________ AGE _____ ____________AGE ____

___________________ AGE _____ ____________ AGE____

MOTHER'S NAME: _______________________ AGE _______ OCCUPATION: __________________________

FATHER'S NAME: _______________________ AGE _______ OCCUPATION: __________________________

EMERGENCY CONTACT: ____ PHONE #: ___________________

CLIENT NAME:_____________________________ DATE:______________

Vivian C. Grout, LMHC

BIOPSYCHOSOCIAL ASSESSMENT

Please fill out this assessment as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.

PRESENTING PROBLEM (be as specific as you can: when did it start, how does it affect you…):

____

____

____

Estimate the severity of above problem (circle one): Mild Moderate Severe Very severe

CURRENT: Marital status:_________ **Live with someone:**_______________ **Name:** ____________**Years:** ___

PAST & PRESENT MARRIAGE/S (years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

____

____

____

____

PRESENT SPOUSE/PARTNER: Education: _____________ **Occupation:** ___________________________

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person)

1. ____
2. ____
3. ____
4. ____
5. ____

PARENTS/STEP-PARENT (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

Father:____

____

Mother:____

____

Step-parents____

____

____

SIBLINGS (name/age, if dead: age and cause of death & brief statement about the relationship):

1.____

2.____

3.____

4.____

5.____

MEDICAL DOCTOR/S (name /phone): ____

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness):

____

____

____

SPECIFY <u>MEDICATION</u> you are presently taking and for what. <u>PRINT</u> clearly:

____

____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments)**:**

____

____

SUICIDE ATTEMPT/S or **VIOLENT BEHAVIOR** (describe: ages, reasons, circumstances, how, etc)

____

____

FAMILY MEDICAL HISTORY (Describe any <u>illness</u> that runs in the family: cancer, epilepsy, etc)**:**

____

____

____

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):

____

____

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Ind/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended)**:**

1. ____

____

____

2. ____

____

____

3. *USE OTHER SIDE OF THE PAGE FOR MORE INFORMATION ABOUT PSYCHOTHERAPISTS*

DESCRIBE YOUR CHILDHOOD IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

____

____

____

IF PARENTS DIVORCED: Your age at the time: ______, Describe how it affected you at the time

____

____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

____

____

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):

____

What gives you the most joy or pleasure in your life?

____

____

What are your main worries and fears?

____

____

What are your most important hopes or dreams?

____

____

Please add on the other side of the page or on a separate page any other information you would like me to know about you and your situation.