SAGINAW Psychological SERVICES

P: 989.799.2100 • F: 989.799.2637
2100 Hemmeter Rd. • Saginaw, MI 48603
www.sagpsych.com

# Notice of Privacy Practices Acknowledgement and Receipt of Client Orientation

**Client Information:**

Last Name: _____First Name: _____

Today's Date: _____Date of Birth: _____

Current Address: _____

Current Phone Number: _____

Additional Phone Numbers: _____

Current Email Address: _____

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and/or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand SPSI's Notice of Privacy Practices, which provides a more complete description of the uses and disclosures of my health information. I understand that SPSI has the right to change its Notice of Privacy Practices from time to time and that I may contact SPSI at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that SPSI restrict how my private information is used or disclosed to carry out treatment, billing/payment or health care operations. I also understand that SPSI is not required to agree to my requested restrictions, but if SPSI does agree, then SPSI is bound to abide by such restrictions.

**Signatures Attesting to Notice of Privacy Practices Acknowledgement:**

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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# Consent to Financial Responsibility and Service Agreement

**Client Information:**

Last Name: _____First Name: _____

Today's Date: _____Date of Birth: _____

**Financial Policy:** All insurance policies, third party insurance administrator and court order payment documents are contracts and/or orders between you and the party listed on those documents. SPSI will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, co-insurance, covered charges, secondary insurances, usual and customary charges, etc, other than to supply information as necessary. You are ultimately responsible for the timely payment of your account. Timely payment is within 30 days of the service rendered date.

**Authorization to Bill Insurance:** I hereby certify and attest that I have sought evaluation, treatment, or medical advice from SPSI. I authorize the medical staff, clinical provider and administrative personnel to release my, or my minor child's medical information, to the insurance company(ies) named below for the purpose of determining and receiving benefits for medical billings. I understand and acknowledge that the SPSI medical provider, clinical provider and/or administrative staff will submit my claim to the insurance company(ies) named below. I further understand that I will be held responsible for any amount of my medical bill that is not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, copayments, coinsurance, and uncovered charges I incur through using services at SPSI.

**Insurance Waivers:** I understand that insurance payers may waive copay or coinsurance from time to time. I further understand that SPSI will consider these waivers as part of the ongoing calculation of the client balance due to SPSI. SPSI will update the SPSI billing system when the insurance payer sends payment to SPSI.

**Health Savings Accounts (HSA) & Employee Assistance Programs (EAP):** I understand that if I have a third-party payer such as an HSA or EAP it will be reviewed by SPSI for consideration as a claim's payer, but there is no guarantee it can be approved for use as a SPSI claims payer. I understand that SPSI can take credit card payments which are linked to my HSA credit account. I understand that SPSI will not bill HSA third party administrators, unless I have received confirmation from SPSI directly. I understand that I am responsible to work with my respective HSA or EAP payer, as necessary. Lastly, I understand that if my session goes over or below what is authorized for time spent in sessions, that I will be charged self-pay rates or billed to my health insurance.

**Adult Children on their Parent(s)/Guardian Insurance Plans:** I understand that I am responsible for my insurance deductibles, fees, copayments, coinsurances, and uncovered charges incurred while using services at SPSI. I understand that I cannot assign my financial responsibility to my parent or guardian without their written consent.

**Primary Insurance Company:** Name of Insurance Company_____
Subscriber ID#: _____ Group #: _____
Policyholder Full Name: _____ Date of Birth: _____
Relationship to You: Self Spouse Child Other: _____ Policyholder Sex: M F

**Secondary Insurance Company:** Name of Insurance Company_____
Subscriber ID#: _____ Group #: _____
Policyholder Full Name: _____ Date of Birth: _____
Relationship to You: Self Spouse Child Other: _____ Policyholder Sex: M F

I understand that any portion of my medical bills that are not covered by insurance will be billed to me at the address I have provided. If I do not receive a bill, I understand I may request one by contacting SPSI. I understand it is my responsibility to inform SPSI when my address changes or my insurance policy changes. Non-compliance or defaulting on payments may result in denial of service and/or legal claim against me for non-payment.

**Signatures Attesting to Notice of Privacy Practices Acknowledgement:**

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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# Consent to Coordination of Care

**Client Information:**

Last Name: _____First Name: _____

Today's Date: _____ Date of Birth: _____

Family Doctor's Printed Name: _____

Family Doctor's Address: _____

Family Doctor's Telephone Number: _____

Family Doctor's Fax Number: _____

I **do** / **do not** (please circle one)

authorize SPSI, my behavioral health care provider and my family doctor (identified and named above) to exchange information regarding my mental health/substance abuse treatment, medical health, psychiatric and therapy records for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care, psychiatric care or substance abuse and/or treatment (as protected under 42 CFR Part) such as diagnosis and treatment plan and medical information, including information regarding the presence or absence of HIV/AIDS. I understand that this authorization shall remain in effect for one year from the date of my signature below. I understand that I may revoke this authorization at any time by providing written notice to SPSI. I further understand that it is my responsibility to notify this provider if I choose to change my family doctor.

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Behavior Health Provider Information (to be completed by provider)

Treating SPSI Provider: _____

DSM V Diagnosis Code and Name: _____

Treatment Modalities:
Psychotherapy: ___ Individual ___ Group ___ Family Frequency of Visits: _____

Notes: _____

Medication Management By: _____
(Physician's name, phone, fax)

Medications prescribed for behavioral health

Date: _____Medication: _____Dosage: _____ Discontinued Date: _____
Date: _____Medication: _____Dosage: _____ Discontinued Date: _____
Date: _____Medication: _____Dosage: _____ Discontinued Date: _____
Date: _____Medication: _____Dosage: _____ Discontinued Date: _____

If authorization is given, a copy of this form should be sent to the Family Doctor

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# Consent to Release Medical Information

**Client Information:**
Last Name: _____First Name: _____
Today's Date: _____ Date of Birth: _____

I authorize SPSI to release and/or obtain medical and/or mental health information contained in my records as specified below and to provide access to, or provide such photocopies, as may be requested of the person or organization and to the extent and nature listed below, subject to the conditions listed below.

**I authorize SPSI to SHARE and RECEIVE information from the following:**

| PRINTED NAME | RELATIONSHIP | PHONE NUMBER |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |

**WILL COVER ONE YEAR SERVICE RANGE unless specified differently: _____**

**Place a "x" next to the information to provide:**

| | | | | | |
|---|---|---|---|---|---|
| | Psychological Evaluation | | Treatment Summary | | Medication Review(s) |
| | Psychiatric Evaluation | | Discharge Summary | | Discharge Instructions |
| | Lab Work Results | | Clinical Psychotherapy Note(s) | | |
| | Other (specify) | | | | |

**Identified information should be disclosed:** | | **VERBALLY** | | **HARD COPY**

**Place a "x" to authorize disclosure of all information related to:** | | HIV/AIDS | | Substance Use

I understand that my records are protected by Federal and State Confidentiality Laws, and cannot be further disclosed without my written authorization, unless release is required by other State or Federal regulations. I understand that there is a possibility the information may be re-disclosed by the recipient of the information and will no longer be protected by the Privacy Rules. I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits. I understand that I may inspect or copy any information released under this authorization. I understand this authorization will expire upon termination of services, or one year from the date of signature. I further understand that, per the Privacy Notice, I may revoke this authorization at any time by notifying Saginaw Psychological Services, Inc, in writing, but that previously disclosed information would be subject to my revocation request.

**Signatures Attesting to My Consent to Release of Information:**

**Client: _____ Date: _____**

**Witness: _____ Date: _____**

— — — — — — — — — — — — — — — — — — — — — — — — — — — — — — — — — — —

**IF YOU LISTED ANYONE ABOVE, PLEASE DO NOT SIGN THE DECLINE LINE BELOW:**

There is no one whom I want SPSI to share information with at this time.
I **DECLINE** this form: Signature: _____ Date: _____
I would like to REVOKE this form. As of today's date, _____, SPSI no longer has permission to share my information. Signature: _____

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# Consent to TeleMedicine Services

TeleMedicine involves the use of electronic communication to enable health care and mental health providers, at locations different from their consumers, to engage in therapeutic services or share medical information for the purpose of maintaining and improving care. The information may be used for diagnosis, therapy, follow up and/or education. While our best efforts are made to safeguard privacy and confidentiality, there is inherent risk in this modality.

**Client Information:**

Last Name: _____First Name: _____

Today's Date: _____ Date of Birth: _____

I am providing my consent to engage in TeleMedicine with SPSI as a part of the behavioral health services I may receive. I understand that TeleMedicine psychotherapy may include: mental health evaluation, assessment, consultation, treatment planning and therapy. TeleMedicine will occur primarily through interactive audio, video and telephone.

By signing this form, I understand and consent to the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to TeleMedicine; this means that no information obtained in the use of TeleMedicine which identifies me will be disclosed to researchers or other entities without my expressed written consent.
2. I understand that the limits of confidentiality that apply to treatment also apply to TeleMedicine; these include a mandated reporting of child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law.
3. I understand that I have the right to withhold or withdraw my consent to the use of TeleMedicine in the course of my care at any time without affecting my right to future care or treatment.
4. I understand that TeleMedicine may involve electronic communication of my protected health information (PHI) to other medical practitioners who may be located in other areas.
5. I understand that it is my duty to inform my treatment provider of electronic interactions regarding my care that I may have with other healthcare providers.
6. I understand that security protocols can fail. Meaning privacy and confidentiality of protected health information cannot be guaranteed with the use of TeleMedicine.
7. I understand that in rare cases, information transmitted may be insufficient to allow for appropriate medical decisions (e.g., poor resolution or sound quality).
8. I understand that delays of treatment may occur due to deficiencies of equipment.
9. I understand that if my provider deems the service he/she is providing to be inappropriate through TeleMedicine, he/she may require the remainder of said services to be carried out in person.
10. I understand that I may expect the anticipated benefits from the use of TeleMedicine in my care, but that no results can be guaranteed or assured.
11. I acknowledge that I have been made aware of the above information regarding TeleMedicine and have reached out to SPSI to answer any questions or concerns I have. I hereby give my informed consent for the use of TeleMedicine with SPSI.

**Signatures Attesting to Notice of Privacy Practices Acknowledgement:**

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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# Consent to Treatment

**Client Information:**
Last Name: _____First Name: _____
Today's Date: _____ Date of Birth: _____

The following is to be read, completed and signed by the client or the client's parent/guardian. If you are a guardian, please provide a copy of the court paperwork (true copy, copy) for our records, legally stating guardianship award.

I agree to attend psychotherapy and/or case management on an individual, family or group basis, as determined with a therapist or examiner. I have read, reviewed, and understand information provided in the Client Handbook, which includes the SPSI Code of Ethics and my Rights. Any questions I may have had, have been answered satisfactorily.

The following pertains only to client seeking SPSI SUD services: I have read, reviewed, and understand the "Know Your Rights" booklet for substance abuse clients. Any questions I may have had, have been answered satisfactorily.

**Signatures Attesting to Consent to Provide Treatment:**

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

The following pertains only to:

- Community Mental Health Clients
  - Includes, but not limited to: SCCMHA, BABHA, MSHN, TBHS
- Medicaid Clients

I have received a copy of the following supplemental booklets and/or pamphlets.
Questions which arose were answered satisfactorily.

- Notice of Privacy Practice – containing "Your Rights" booklet information
- Community Mental Health specific brochures and handbooks
  - Includes, but not limited to: SCCMHA, BABHA, MSHN, TBHS
- Person Centered Planning brochure

**Signatures Attesting to Receipt of the Above Documents:**

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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# Consent to Discharge

**Client Information:**
Last Name: _____First Name: _____
Today's Date: _____ Date of Birth: _____

**Discharge Policy:** Under certain circumstance, clients may be discharged for cause from treatment or participation in services at Saginaw Psychological Services, Inc. Conditions that may precipitate involuntary discharge are as follows:

- Acts of violence against either staff or other clients of the agency
- Threats of violence against either staff or other clients of the agency.
- Failure to maintain scheduled appointments.
- Failure to remain in regular contact with SPSI for more than thirty (30) days.
- Failure to work toward treatment plan objectives.
- Failure to adhere to these SPSI agreements and policies.
    - Financial Responsibility
    - Coordination of Care
    - TeleMedicine Services

Client discharge decisions are made by the SPSI clinical program director in consultation with your primary clinician. Acts or threats of violence may result in immediate discharge by the clinical staff present at the time of such an act.

I understand that in the instance of involuntary discharge, I have the right to appeal the discharge to the clinical program director and recipient rights personnel.

If I am being considered for involuntary discharge; I will be notified of this in writing. In cases of acts or threats of violence, written discharge is not provided, rather a verbal discharge at the time of the incident is provided.

I have reviewed and understand the criteria for discharge as described above.

**Signatures Attesting to My Agreement:**

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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# HEALTH HISTORY FORM

SmartCare ID: _____ Date: _____

Legal name for Insurance purposes: _____

Name (if different than legal): _____

Pronouns: _____

Gender Identity: _____

Sex Assigned at Birth: Male __ Female __ Intersex __

Significant relationship:

___ single
___ married
___ monogamous
___ polyamorous
___ life partnership

Family Doctor's name: _____ phone number: _____

Preferred pharmacy name: _____ phone number: _____

In case of emergency, please contact: _____ phone number: _____

Additional emergency contact: _____ phone number: _____

Language(s) spoken at home: _____

Are you pregnant: Yes ___ No ___

Are you receiving prenatal care: Yes ___ No ___

Most recent hospitalization: _____ Why: _____

| CURRENT MEDICATIONS | HOW WELL DO THEY WORK ON A SCALE OF 0 to 10 (0 = did not work at all – 10 = worked very well) |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

| PAST MEDICATIONS | HOW WELL DID THEY WORK ON A SCALE OF 0 to 10 (0 = did not work at all – 10 = worked very well) |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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Do you have any allergies or adverse reactions to medications? If yes, please list the medication and the reaction below:

_____ _____
_____ _____
_____ _____
_____ _____

Do you use any substances? Yes ___ No ___

If Yes, what? _____

Do you have any current or past health conditions? Yes ___ No ___

If Yes, what? _____

Have you had any surgical procedures? Yes ___ No ___

If Yes, what? _____

Research has shown that, in many cases, complimentary approaches to mental health can help increase well-being, ease symptoms of depression, reduce anxiety, and/or aid relaxation. Do you use any of the following to help manage your symptoms?

Meditation: Yes ___ No ___

Yoga: Yes ___ No ___

Acupuncture: Yes ___ No ___

Massage Therapy: Yes ___ No ___

Art Therapy: Yes ___ No ___

Dance: Yes ___ No ___

Tai Chi: Yes ___ No ___

Other: _____

Here at SPSI, we want to make sure that all the information we share with you and present to you is clear and understandable. For this purpose, it is important for us to know if you are able to read all your paperwork, or if you need support in this area. What is your best estimate of your reading grade level?

_____ grade level

Client Signature

Witness Signature

Name: _____ ID # _____ Date: _____

**PC-PTSD-5**

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide

Have you ever experienced this kind of event?
Yes No
If no, screen total = 0. Please stop here.
If yes, please answer the questions below.

In the past month, have you …

1. had nightmares about the event(s) or thought about the event(s) when you did not want to? Yes No

2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? Yes No

3. Been constantly on guard, watchful, or easily startled? Yes No

4. Felt numb or detached from people, activities, or your surroundings? Yes No

5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? Yes No

PC-PTSD-5 (2015)

National Center for PTSD


*If this screen has any answers of "Yes" then fill out PCL-5

**Saginaw Psychological Services**
**Controlled Substance Agreement**

Client Name: _____ Date of Birth: _____

The purpose of this contract is to prevent misunderstandings about the medications you are prescribed by Saginaw Psychological Services, Inc.

You may be prescribed a controlled substance for the treatment of your psychiatric illness(es). It is important that you understand the risks and responsibilities that accompany this treatment. You are ultimately responsible for your physical and emotional health.

This agreement will help you and your prescriber to comply with the law(s) regarding controlled pharmaceuticals.

MAPS (Michigan Automated Prescription System) is a database operated by the State of Michigan that requires all pharmacies to report any controlled substances that they dispense to a patient. This report lists all controlled substances that you pick up from any pharmacy in Michigan and will be monitored to help ensure compliance with this contract.

- I agree not to sell, share or give any medications to another individual.
- I understand that any mishandling of my medications is a violation of this agreement and will result in treatment being terminated (this includes any attempt to alter a prescription).
- I understand that any medical treatment is initially a trial and that continued prescription is based on evidence of benefit. I understand that if my symptoms are not improved or my ability to function is not improved with the medication prescribed, it may be stopped or changed. I will work with my therapist and/or case manager and/or prescriber to maintain realistic expectations of what medication can do for my illness(es). I am agreeable to therapy as a treatment option and know I am responsible to make and keep scheduled appointments.
- I will not attempt to obtain any anti-anxiety medications, sleeping pills or stimulants from another prescriber.
- I will safeguard my medications from loss or theft. I understand that any lost, stolen, or destroyed prescriptions for controlled substances will **NOT** be replaced even with a police report. I will not call the office to report medication lost, stolen or destroyed in effort to obtain refills or additional prescriptions.
- I agree to submit to a urine drug screen if requested by my prescriber.
- I will not use recreational drugs, street drugs or alcohol.
- I understand that if I become pregnant I must notify my prescriber as soon as possible.
- I will report all medications that I am taking (including, but not limited to Methadone, Medical Marijuana, Suboxone and pain medication) to my Saginaw Psychological Services provider. I also agree to sign releases for my prescriber to communicate with all other healthcare providers that are prescribing medications(s) for me.
- I understand that running out of medication early, needing early refills, taking more than prescribed and losing prescriptions may be signs of misuse of the medications and may be reasons for my prescriber to discontinue the medications I have been prescribed.

If you have any questions regarding this information, please request clarification before signing.

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If you have any questions about our Privacy Practices,

ask your Privacy Officer

SPSI Privacy Officer

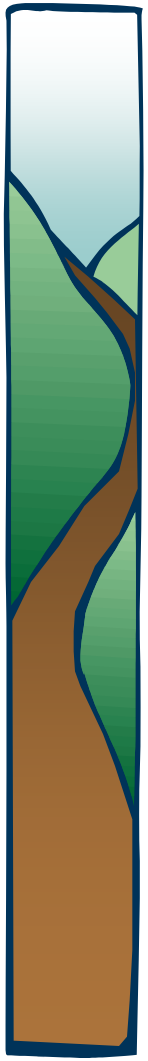
Matthew Helsius

989-799-2100

2100 Hemmeter, Saginaw, MI 48603
Phone (989) 799-2100 Fax (989) 799-2637

This design, along with the policies and procedures within this book, were adapted from the Notice of Privacy Practices booklet originally designed by the Saginaw County Community Mental Health Authority.

# *Saginaw Psychological Services, Inc.*



# *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. Effective: September 7, 2014

## Our Commitment to Your Privacy

We are dedicated to maintaining the privacy of your health information. In conducting business, we will create records regarding you and the treatment and services we will provide.

These records are the property of our agency. However, we are required by law to:

- Maintain the confidentiality of your health information.
- Provide you with the notice of our legal duties and privacy practices concerning your health information.
- Follow the terms of our notice of privacy practices in effect at the time.

This notice provides you with the following information:

- How we may use and disclose your health information.
- Your privacy rights in health information.
- Our obligations concerning the use and disclosure of your health information.

## How We May Use and Disclose Your Health Information

The following categories describe the different ways that we may use and disclose your health information. Note: not every possible use or disclosure is specifically mentioned

**For Treatment**: We will use clinical information about you to provide you with treatment and services. We will disclose medical information about you to doctors, nurses, case managers/support coordinators, and other office personnel who are involved in providing you with treatment.

**For Payment:** We may use and disclose medical information about you so that treatment and services received from our agency may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about treatment you received so your health plan will pay us or reimburse you for treatment. We may also tell your health plan about a treatment you are going to receive, to obtain prior approval or to determine whether your plan will cover the treatment.



## Revisions to this Notice

We reserve the right to revise this notice. Any revised Notice will be effective for information currently in our possession as well as any information received in the future. We will post a copy of any revised notice. Any revised notice will contain on the first page, in the bottom right-hand corner, the effective date.

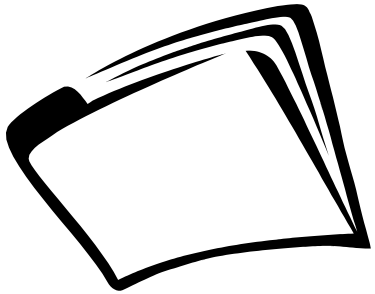
## Complaints

If you believe your privacy rights have been violated, you may file a complaint with this office or the Secretary of the Department of Health and Human Services. To file a complaint with this office, contact your Privacy Officer. All complaints must be submitted in writing, or followed up in writing.

You will not be penalized in any way for filing a complaint.

## Other Uses for Medical Information

Other uses and disclosures of your medical information not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide us such an authorization in writing to use or disclose medical information about you, you may revoke that authorization, in writing at any time. If you revoke any authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization.



**Your Rights Regarding Your Health Information (Continued)**

To request an amendment, your request must be made in writing and submitted to the Privacy Officer. We may deny your request if you ask us to amend information that:

a) Was not created by us;

b) Is not part of the medical information kept by this office;

c) Is not part of the information that you would be permitted to inspect and copy;

d) Is accurate and complete.

**Right to Accounting of Disclosures:** You have the right to request an "accounting of disclosures." This is a list of the disclosures this office has made of your medical information. To request an accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years.

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the use or disclosure we make of your medical information.

We are not required to agree to your request for a restriction. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If you have paid for services out-of-pocket, in full, and if you request that our office does not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where SPSI is required by law to make a disclosure.

To request a restriction, you must make the request in writing to our Privacy Officer.

**Confidential Communications:** You have the right to request we communicate with you only in a certain manner. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Privacy Officer. We will accommodate all reasonable requests.

**Right to a Paper Copy**

You have the right to a paper copy of this Notice. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice at our office. To obtain a paper copy of this Notice, contact the SPSI Privacy Officer.



**For Health Care Operations:** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run our office and make sure that all of our consumers receive quality care. Examples: Our organization may use your health information to evaluate the quality of care you received, or to conduct cost-management or business planning activities for our organization. Further, we may disclose your information to doctors, nurses, students, and other personnel for review and learning purposes. We may remove identifying information from your medical information so others may use it to study health care and heath care delivery without learning the identity of specific clients.

**For Appointment Reminders or Treatment Alternatives:** Our organization may use and disclose your health information to remind you that you have an appointment, or to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**To Business Associates:** We may share your health information with "business associates" that perform services for us (such as attorneys) through contracts that we have them. These contracts identify terms that safeguard your health information.

**Marketing**: Uses and disclosures of any protected health information for marketing purposes and disclosures that constitute the sale of PHI require your authorization.

**Psychotherapy Notes**: Most uses and disclosures of psychotherapy notes will be done only with your authorization.

**Other Uses of Medical Information**: Other uses and disclosures of your medical information not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide us with an authorization in writing to use or disclose medical information about you, you may revoke that authorization, in writing at any time. If you revoke authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization.

**To Others Involved in Your Healthcare:** Unless you object, we may disclose to a family member, a relative, a close friend, or any other person that you identify, your health information that directly relates to that person's involvement in your care or payment related to your care. If you are not able to agree or object to a disclosure, we will use our professional judgment regarding such disclosure.

**Breach Notification**
We are required to notify you following a breach of your unsecured PHI.

**Use And/Or Disclosure to the Recipient**
If a valid authorization is provided, SPSI may use or disclose your health information to you, as a recipient of our services, your guardian with authority to authorize such use or disclosure, the parent with legal custody of a minor recipient, or the court appointed personal representative or executor of the estate of a deceased recipient, unless in the written judgment of SPSI the disclosure would be detrimental to you, as the recipient, or others.

**As Required by Law:** We will disclose medical information about you when required by federal, state, or local law. For example, disclosure may be required by Worker's Compensation statutes or various public health statues in connection with required reporting of certain diseases, abuse and neglect, domestic violence, adverse drug reactions, etc.

**Health Oversight Activities:** We may disclose medical information to a governmental or other oversight agency for activities authorized by law. For example, disclosures of your medical information may be made in connection with audits, investigations, inspections, and licensure renewals.

**Lawsuits and Similar Proceedings:** If you are involved in a lawsuit or dispute, we may use your medical information to defend the office or to respond to a court order. We also may disclose your health information in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

**Law Enforcement:** We may release medical information about you if required by law when asked to do so by a law enforcement official.

**Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death.

**Research:** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who have received a medication to those who received another medication for the same condition.



**To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

**For Specialized Government Functions:** Our organization may disclose your health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate military command authorities. In addition, we may disclose your health information to federal officials for intelligence and national security activities authorized by law. We also may disclose your health information to federal officials in order to protect the President, other officials, or foreign heads of state, or to conduct investigations. Our organization may disclose your health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (1) for the institution to provide health care services to you, (2) for the safety and security of the institution, and/or (3) to protect your health and safety or the health and safety of other individuals.

## Your Rights Regarding Your Health Information

You have the following rights regarding the health information that we maintain about you:

**Right to Inspect and Copy:** You have the right to inspect and copy your medical information with the exception of any psychotherapy notes. To inspect and copy your medical information you must submit your request in writing to the Privacy Officer.

If you request a copy of the information, we may charge for the time spent, costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. For information regarding a review, contact the Privacy Officer.

**Right to Amend:** If you feel medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by this office.