

Nicole Peeke."NEUY "%85074"
36; 2'P0Ertgo qpV'Drkf 0"Uwkg"426
"*****"Ertgo qpV, CA 91933
"*****"(323) 345-1402

Client Information

Date: _____

Name: _____

Birth Date: _____ Age: _____ Gender: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

What method is best for communication with you? Home _____ Cell _____ Email _____

Is it okay to leave a message for you at your preferred number? Yes _____ No _____

Is it okay to contact you via email? Yes _____ No _____

Please provide a password that only you and I will know so that I can send you encrypted email (for anything other than scheduling): _____

Relationship/marital status: _____

Occupation: _____ Highest Education Completed: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Please list medications you take and dosages:

Have you been hospitalized for psychological reasons or drug dependency? Yes _____ No _____

If yes, please briefly describe: _____

Psychiatrist (if applicable): _____ Phone: _____

Have you previously been in psychotherapy? If so, when and for what reason(s)? Was it helpful or not? _____

Do you have any previous suicide attempts, self-destructive behaviors, or violent behaviors? (Indicate age, circumstances, and whether it led to hospitalization or legal problems)

Current reason(s) for seeking therapy: _____

Estimate the severity of the problem for which you are seeking care:

Mild Moderate Severe Very Severe

How many sessions or how much time do you think you need to successfully resolve this problem?

1 – 10 sessions

10 – 20 sessions

20 or more sessions

Ongoing, longer-term therapy

How did you learn about our practice? _____

Referred by: _____

Who Is Financially Responsible for this account? Who is the insured?

Name: _____

Relationship to Patient: _____

Date of Birth of Policy Holder: _____

Driver's License# _____

Address (if different than patient):

City, State, Zip:

Employer: _____

Occupation: _____

Authorization and Release:

- ❖ I authorize the release of necessary information to third party payers/insurance companies and/or other health practitioners.
- ❖ I authorize the release of necessary information to Verdant Oak Behavioral Health, Inc., administrator.
- ❖ I am informed of HIPAA guidelines and regulations related to confidentiality of medical records.
- ❖ I agree to be responsible for payment of all services rendered on my behalf or for my dependents.
- ❖ I agree to notify your office more than 24 business hours in advance if I need to reschedule or cancel an appointment.

X _____

Signature and Printed Name of Responsible Party

Date

Verdant Oak Behavioral Health, Inc.

36; 2'P 0Ertgo qpV'Dixf0 Suite 206
Claremont, CA 91711

Credit Card Authorization

Please make no marks nor add any comments to this page of the document. It is your consent to make payment for services rendered, and your treatment is conditional upon your signing of this consent form without modification. This form will be securely stored in your clinical file and may be updated at any time upon request.

You may opt out of leaving a credit card on file with us; however, you will then need to leave a cash or check deposit in the amount equivalent to full fee for two therapy sessions or in the amount of \$450 for testing/assessment services.

In the event that you miss or fail to cancel an appointment within 24 business hours of the scheduled time, or if a check is returned unpaid, you will be charged the full session fee.

An additional \$25 fee will be assessed for: 1) returned checks, and/or 2) inaccurately disputed charge-backs.

I, _____, hereby authorize Verdant Oak Behavioral Health, Inc. to bill my credit card at the usual fee for professional services including all of the following:

- ❖ Appointments and/or copayments that I elect to pay for by credit card
- ❖ **Missed appointments**
- ❖ Telephone and email consultations
- ❖ Appointments that I have cancelled with less than 24 business hours notice
- ❖ Returned checks
- ❖ Fees not covered by insurance or insurance payments made to patient rather than provider

Credit Card Type (check one):

Visa MasterCard Discover American Express

Card # _____ Expiration Date: _____

Verification/Security Code (3 or 4-digit code on back of card by signature line): _____

Name as Printed on Card: _____

Billing Address: _____

City: _____ State: _____ ZIP: _____

By signing below I am authorizing Verdant Oak Behavioral Health, Inc. to bill my credit card at the usual fee for professional services as described above.

Signature: _____ Date: _____

Nicole Peeke, LEUY
36; 2'P0Ertgo qpV'Drx f0
*****Uite 206
*****Claremont, CA 91711
*****Lic. #: 65074

AGREEMENT, INFORMED CONSENT, OFFICE POLICIES AND GENERAL INFORMATION

This form provides you (patient) with information that is additional to that detailed in the Notice of Privacy Practices and it is subject to HIPAA pre-emptive analysis.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law. Below is a non-exhaustive list of circumstances when disclosure is, or, may be, required by law. The list is not exhaustive because the laws in this area change from time. However, the list is designed to give you an idea of some of the circumstances where disclosure may be required.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled or when client's family members communicate to Ms. Peeke that the client presents a danger to others.

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Ms. Peeke. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. Ms. Peeke will use her clinical judgment when revealing such information. Ms. Peeke will not release records to any outside party unless she is authorized to do so by all adult family members who were part of the treatment.

Emergencies: If there is an emergency during our work together or in the future, after termination, where Ms. Peeke becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, she will do whatever she can, within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, she may also contact the person whose name you have provided on the biographical sheet.

Health Insurance & confidentiality of records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Verdant Oak Behavioral Health, Inc. is an administrative agent of Ms. Peeke

for the purposes of processing claims information and will have limited access to that information needed to process any health insurance claims. Ms. Peeke has no control or knowledge over what insurance companies do with the information she submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future ability to obtain insurance, other benefits or even a job. The risk stems from, among other things, the fact that mental health information is likely to be entered into insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database always carries some risk because computers are inherently vulnerable to break-ins and unauthorized access. Medical data has also been reported to be legally accessed by enforcement and other agencies, which also puts you in a vulnerable position.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client's) nor your attorney's, nor anyone else acting on your behalf, will call on Ms. Peeke to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

Consultation: Ms. Peeke consults regularly with other professionals regarding the treatment and well-being of her clients; however, client's identity remains completely anonymous, and confidentiality is fully maintained.

E - Mails, Cell phones, Computers and Faxes: It is very important to be aware that computers and e-mail and cell phone communication can be relatively easily accessed by unauthorized people and, hence, can compromise the privacy and confidentiality of such communication. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Additionally, Ms. Peeke's e-mails are not encrypted. Faxes can easily be sent erroneously to the wrong address. Ms. Peeke's computers are equipped with a firewall, virus protection and a password, and she also backs up all confidential information from her computers onto an external drive on a regular basis. The drive is stored securely off-site. Please notify Ms. Peeke if you decide to avoid or limit in any way the use of any or all communication devices, such as e-mail, cell-phone or faxes. If you communicate confidential or highly private information via e-mail, Ms. Peeke will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and she will honor your desire to communicate on such matters via e-mail. Please do not use e-mail or faxes for emergencies.

Records and Your Right to Review Them: Both the law and the standards of Ms. Peeke's profession require that she keeps appropriate treatment records for at least seven years. If you have concerns regarding the treatment records, please discuss them with Ms. Peeke. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when Ms. Peeke assesses

that releasing such information might be harmful in any way. In such a case, Ms. Peeke will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, upon your request, Ms. Peeke will release information to any agency/person you specify. When more than one client is involved in treatment, such as in cases of couple and family therapy, Ms. Peeke will release records only with the signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact Ms. Peeke between sessions, please leave a message at (323)345-1402, and your call will be returned as soon as possible. Ms. Peeke checks her messages a few times during the daytime only, unless she is out of town. If an emergency situation arises, indicate it clearly in your message, and if you need to talk to someone right away call Los Angeles Psychiatric Emergency Team: 800 854-7771, Las Encinas Hospital (800) 792-2345 or the Police: 911. Please do not use e-mail or faxes for emergencies. Ms. Peeke does not check her e-mail or faxes daily.

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay their standard agreed upon fee to Verdant Oak Behavioral Health, Inc., administrative agent (“VOBH”) for Ms. Peeke, at the end of each session unless other arrangements have been made. VOBH is the administrative agent for Ms. Peeke responsible for all billings and scheduling for Ms. Peeke. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Please notify VOBH if any problems arise during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, VOBH will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement if you so choose. As was indicated in the section *Health Insurance & Confidentiality of Records*, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are dealt with in psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If your account is overdue (unpaid) and there is no written agreement on a payment plan, VOBH, as Ms. Peeke's agent, can use legal or other means (courts, collection agencies, etc.) to obtain payment. Ms. Peeke also reserves the right to suspend and/or terminate treatment if your account is overdue and no other arrangements are made.

MEDIATION & ARBITRATION: All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of Ms. Peeke and the client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Los Angeles County, CA. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, Ms. Peeke or her agent can use legal means (court, collection agency, etc.) to obtain payment. The prevailing

party in arbitration or collection proceeding shall be entitled to recover a reasonable sum as and for attorneys' fees. In the case of arbitration, the arbitrator will determine that sum.

VERDANT OAK BEHAVIORAL HEALTH, INC.: VOBH is an administrative agent for Ms. Peeke and its responsibilities are limited to scheduling sessions with Ms. Peeke, administration and any collections, billing or payment. VOBH is an assignee of Ms. Peeke's right to collect payments from you but Client understands that VOBH has no supervisory power over Ms. Peeke and, in fact, it is Ms. Peeke that has retained VOBH as her administrative agent. Client hereby acknowledges that VOBH has no actual or potential liability to Client on any actual or potential claim arising out of the treatment by Ms. Peeke of Client.

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Ms. Peeke will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc, or experiencing anxiety, depression, insomnia, etc. Ms. Peeke may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, Ms. Peeke is likely to draw on various psychological approaches according, in part, to the problem that is being treated and her assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive-behavioral, cognitive, psychodynamic, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational. Ms. Peeke provides neither custody evaluation recommendation nor medication or prescription recommendation nor legal advice, as these activities do not fall within her scope of

Discussion of Treatment Plan: Within a reasonable period of time after the initiation of treatment, Ms. Peeke will discuss with you (client) her working understanding of the problem, treatment plan, therapeutic objectives and her view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, Ms. Peeke's expertise in employing them, or about the treatment plan, please let Ms. Peeke know. You also have the right to ask about

other treatments for your condition and their risks and benefits and Ms. Peeke will use her best efforts to inform you of those treatments.

Termination: As set forth above, after the first couple of meetings, Ms. Peeke will assess if she can be of benefit to you. Ms. Peeke does not accept clients who, in her opinion, she cannot help. In such a case, she will give you a number of referrals whom you can contact. If at any point during psychotherapy Ms. Peeke assesses that she is not effective in helping you reach your therapeutic goals or that you are non-compliant, she will, upon discussion with you and, if appropriate, terminate treatment. In such a case, she would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, Ms. Peeke will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, Ms. Peeke will assist you with referrals, and, if she has your written consent, she will provide her or him with the essential information needed. You have the right to terminate therapy at any time; however, you will be responsible for any unpaid balance at that time. If you choose to terminate therapy, if appropriate, Ms. Peeke will offer to provide you with names of other qualified professionals.

DUAL RELATIONSHIPS: A multiple relationship occurs when a social work professional is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the social work professional has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person. Not all dual or multiple relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs Ms. Peeke's objectivity, clinical judgment or can be exploitative in nature. Ms. Peeke will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. Claremont, CA is a small community and many clients know each other and Ms. Peeke from the community. Consequently, you may encounter someone you know in the waiting room or Ms. Peeke in the community. Ms. Peeke will never acknowledge working with anyone without his/her written permission. Ms. Peeke will discuss with you, her client/s, the often-existing complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. Dual or multiple relationships can enhance trust and therapeutic effectiveness but can also detract from it, and often it is impossible to know that ahead of time. It is your, the client's, responsibility to communicate to Ms. Peeke if the dual or multiple relationship becomes uncomfortable for you in any way. Ms. Peeke will always listen carefully and respond accordingly to your feedback and will discontinue the dual relationship if she finds it interfering with the effectiveness of the therapy or the welfare of the client, and of course, you can do the same at any time.

CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours (1 day) notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.



Verdant Oak Behavioral Health

"36; 2'P 0Ertgo qpv'Drxf 0'Uwkg'426
'Ertgo qpv, CC"; 3933

""""VGNO(323) 345-1402
www.XQDJ .org

INFORMED CONSENT ADDENDUM

THERAPY CLIENT REVISED CANCELLATION POLICY

Therapy clients are typically scheduled on a weekly or bi-weekly basis. That time is specifically reserved for you. Consistent attendance optimizes your progress and can reduce the duration of treatment. While we recognize that unanticipated conflicts can arise, we encourage clients to reschedule missed appointments when possible.

When cancelling an appointment, please try to do so the week prior to the scheduled session. You are responsible for the full session fee (not your copay) for sessions cancelled less than 24 hours in advance and for sessions you do not attend without notice. A maximum of three (3) same-week cancellations will be allowed in one calendar year. Subsequent same-week cancellations will be billed using the following scale:

Fourth same-week cancellation: \$50

Additional same-week cancellations, late cancellations, and missed appointments: FULL FEE

NOTE: The above charges are your responsibility. Insurance companies DO NOT cover cancellation and/or missed appointment fees.

DURATION OF APPOINTMENTS AND PROMPTNESS

Initial sessions take between 60 and 90 minutes. Subsequent therapy sessions are scheduled for between 45 and 50 minutes. If you are more than 20 minutes late for a session and have not notified us that you are coming, the doctor will assume you had to cancel your session and may not be in the office if you arrive for the appointment thereafter.

Client Signature

Date

Client or Guardian Signature

Date

*****Nicole Peeke, LCSW
36; 2"P 0Erntgo qpVDrxf 0"Uwkg"426
""Claremont, CA 91711
""Lic. #: 65074

**Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations**

I understand that as part of my healthcare, this organization and its administrator, Verdant Oak Behavioral Health, Inc. originate and maintain health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means for Verdant Oak Behavioral Health, Inc. to bill for services rendered
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Signature _____

Date: _____

Witness _____

Date _____

HIPAA Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ See page 2 for more information on these rights and how to exercise them

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ See page 3 for more information on these choices and how to exercise them

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ See pages 3 and 4 for more information on these uses and disclosures

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
-

Do research

- We can use or share your information for health research.
-

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
-

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.
-

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
-

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
 - For workers' compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services
-

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following provider:

Nicole Peeke, LCSW License #
65074
1490 N. Claremont Blvd., Suite 204
Claremont, CA 91711
T E L 323---345---1402

Effective Date: March 26, 2013