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

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL/MEDICAL INFORMATION ABOUT YOU MAY BE USED/DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of protected health information (PHI) for treatment, payment, and health care operations, and the law requires that I obtain your signature acknowledging that I have provided you with this information by the end of our first session.

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 psychologist.
  - *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, applying, 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 operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is 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 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 you give me information which leads me to suspect child abuse, neglect, or death due to maltreatment, I must report such information to the appropriate State agencies. If asked by a State agency representative to turn over information from your records relevant to a child protective services investigation, I must do so.
- **Adult and Domestic Abuse:** If information you give me gives me reasonable cause to believe that a disabled adult is in need of protective services, I must report this to the appropriate State agencies.
- **Health Oversight:** The New Hampshire Psychology Board has the power, when necessary, to subpoena relevant records if I am the focus of an inquiry.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding, and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without your written authorization or a court order. This 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:** I may disclose your confidential information to protect you or others from a serious threat of harm by you.

- **Worker's Compensation:** If you file a workers' compensation claim, I am required by law to provide your mental health information relevant to the claim to your employer and the New Hampshire Industrial Commission.

IV. Patient's Rights and Psychologist's Duties

Patient'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 seeing me. Upon your request, I will send your bills to another address.)
- *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. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial 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 for which you have neither provided consent nor authorization (as described in Section III of this Notice). 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.

Psychologist'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 policies 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 my policies and procedures, I will verbally inform patients of any changes, post a revised notice in the office, and have copies of the notice available for patients at their request.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, have other concerns about your privacy rights, believe that your privacy rights have been violated and wish to file a complaint, you should contact the Office for Civil Rights, U. S. Department of Health and Human Services, JFK Federal Building – Room 1875, Boston, MA 02203, (617)565-1340, (617)565-1343 (TDD). You can obtain a Fact Sheet on How to File a Health Information Privacy Complaint with the Office for Civil Rights, which outlines the steps for filing a written complaint, either at http://www.hhs.gov/ocr/privacyhowtofile.htm or directly from me by request.
You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice went into effect on Monday April 14, 2003
I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If I revise my policies and procedures, I will verbally inform clients of any changes, post a revised notice in the office, and have copies of the notice available for clients at their request.

CIGNA Behavioral Health Participant Rights and Responsibilities

Participant Rights and Responsibilities

As a participant, you have the right to receive services:

- That respect your privacy and dignity.
- That are provided in a prompt, courteous and respectful manner.
- That respect your cultural and ethnic identity, religion, disability, gender, age, marital status and sexual orientation.
- That are provided in a physical environment that is safe, sanitary, allows for effective treatment, which safeguards the privacy and confidentiality of interactions with your practitioner, and is free from observation by third parties, unless consent is obtained from you.
- From practitioners who are qualified, competent, focused on your care, and reasonably accessible to you.
- That emphasize your participation in developing a treatment plan specific to your needs, and include your agreement to work toward defined goals.
- That in relation to admission, discharge, or treatment is free of discrimination on the basis of age, sex, race, creed, color, national origin, ethnicity, religion, marital status, disability or sexual orientation.

As a participant, you have the right to current information concerning:

- Your diagnosis, recommended medically appropriate treatment options that relate to your care, potential alternatives and accompanying risks, benefits, and costs (in writing for Medicare participants). This information, regardless of cost or benefit coverage, will be explained in terms and in a language that you can reasonably understand.
- Written financial agreements you entered for treatment services rendered.
- Possible consequences of refusing treatment plan recommendations.
- Circumstances or conditions under which you may be transferred to another treatment program or facility, and the accompanying risks, benefits and cost of such a transfer.
- CIGNA Behavioral Health (CIGNA), its services, and the names and credentials of practitioners and providers involved in your care.
- Your responsibilities to ensure better treatment outcomes.
- Your records, and having information explained or interpreted as necessary, except when protected or restricted by law.
- How to access services, including any emergency services needed outside of normal business hours or when you are away from your usual place of residence or work, by using the indicated number on the benefit card, or by independently accessing CIGNA Behavioral Health On-line resources, or through arrangement with an existing treatment provider.
- How CIGNA Behavioral Health evaluates new technology for inclusion as a covered benefit.
- Assistance in selecting a new behavioral healthcare delivery office or practitioner if your current practitioner is affected by termination or closure.
- Resources and procedures available through CIGNA Behavioral Health for communicating concerns or questions, for expressing dissatisfaction with services or care, and for requesting an appeal if not satisfied with any decisions regarding dissatisfaction with services or care including the provision of language services for the complaint and appeal process.
- Services available to you and charges for those services including services not covered under your health plan's benefits.
- Resources and procedures available through CIGNA Behavioral Health to make suggestions about CIGNA Behavioral Health's rights and responsibilities policies.

If you would like to express a concern or dissatisfaction with the care or services you have received, please contact CIGNA Behavioral Health or the office of the practitioner where you received services, and inquire as to the steps of the Complaint and Appeal process.

As a participant, you have the right to protection of privacy and confidentiality:

- In case discussions, examinations, and treatment services.
- In communications and records pertaining to care, except in cases such as suspected child abuse and danger to yourself or others, when reporting is permitted or required by law, or in instances of medical emergency, or when the coordination of care with a primary care physician is required by a health plan, or when disclosure is authorized by court order or court subpoena.
- If you use a medical benefits plan to pay for services and you are not the person who signed up for the coverage as the primary policy holder, be aware that billing statements, claim information and coordination

of benefits questions will be sent to the primary policy holder, not to you, unless you contact Customer Service at 800.926.2273 and ask for correspondence to be sent directly to you.

Statement on confidentiality of alcohol and drug abuse records: CIGNA Behavioral Health staff and network practitioners will not identify a participant as involved in alcohol or substance abuse treatment to others outside the treatment program, unless:

- The participant consents in writing; OR
- The disclosure is allowed by court order; OR
- The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; OR
- The disclosure is made to a primary care physician to coordinate care when required by a health plan and the participant consents verbally or in writing; OR
- The participant commits or threatens to commit a crime at the treatment program or against any person who works for the program; OR
- There is suspected child abuse or neglect or a danger to yourself or others when reporting is permitted or required under state laws to appropriate state or local authorities.

As a participant, you are responsible for:

- Being honest about facts, feelings or ideas that relate to your care.
- Supplying information that your practitioner(s) and/or provider(s) need in order to provide care and/or that CIGNA Behavioral Health may need to determine benefit coverage.
- Attempting to understand clinical problems that are identified and attempting to follow the plans and instructions for care you have agreed on with your practitioner.
- Taking an active part in your treatment planning and therapy.
- Keeping appointments and cooperating with CIGNA Behavioral Health staff and participating practitioners.
- Knowing the names of persons who are providing your care.
- Reporting changes in your condition to your practitioner.
- Informing your practitioner if you anticipate problems in following prescribed treatment.

Revision Date: July 2011

OMB Control Number: 0938-NEW
Expiration Date: XX/XXXX

"Good Faith Estimate for Health Care Items and Services" Under the No Surprises Act
(For use by health care providers, facilities, and providers of air ambulance services no later than 1/1/22)

Under Section 2799B-6 of the Public Health Service Act and its implementing regulations, health care providers, health care facilities, and providers of air ambulance services are required to provide a good faith estimate of expected charges for items and services to individuals who are not enrolled in a group health plan or group or individual health insurance coverage, or a Federal health care program, or a Federal Employees Health Benefits (FEHB) program health benefits plan (uninsured individuals) or not seeking to file a claim with their group health plan, health insurance coverage, or FEHB health benefits plan (self-pay individuals) in writing (and may also provide it orally, if an uninsured (or self-pay) individual requests a good faith estimate in a method other than paper or electronically), upon request or at the time of scheduling health care items and services. For ease of reference, for purposes of this document, the term "provider" should be considered to include providers of air ambulance services.

You have the right to receive a "Good Faith Estimate"
explaining how much your medical care will cost

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit
www.cms.gov/nosurprises

Sources:
https://www.cms.gov/files/document/good-faith-estimate-example.pdf
https://www.apaservices.org/practice/legal/managed/good-faith-estimate-compliance

GENERAL INFORMATION

Demographic and Current Social Information:

Name:_____

Phone: (Home)_____(Work)_____(Cell)_____

At which phone numbers may I contact you and/or leave messages?_____

Email:_____

May I email you?_____

Home Address:_____

Gender: Male_____Female_____ Date of Birth:_____

Social Security Number:_____

Marital Status: _____

Describe any previous relationships/marriages:_____

_____

Present Living Arrangements (relationships, not names, and duration):_____

_____

Who is the person you are closest to? (briefly describe relationship and duration, including age, gender, ethnicity, marital status, and occupation):_____

_____

_____

Any history of abuse (emotional, physical, sexual) in current or previous relationships? YES NO

How many children do you have? (ages, genders, and significant problems if applicable):_____

_____

_____

Current Employment Status: Full Time_____ Part Time_____

Student_____ Homemaker_____ Retired_____ Disabled_____

Other: _____

Employer:_____ Occupation:_____

How long have you worked there?_____How long in this occupation?_____

Any significant work experiences? Any problems with performance, attendance, difficulties with co-workers? YES NO

Education (list highest level of education attained or last completed grade if currently in school): _____

_____

Any significant school experiences? Any problems with truancy, suspensions, special education, social or academic performance? YES NO

List any clubs and organizations you belong to:_____

_____

Where does your greatest source of socialization/social support come from?_____

_____

What do you do for pleasure and relaxation?_____

_____

Cultural Background: _____

Military Experience: _____

Religious Affiliation: _____

Emergency contact name and phone number:_____

Family History:

Please provide ages (or date of death), marital status, occupation, and quality of relationship (none, poor, fair, or good) for the following family members:

Mother:_____

Father:_____

Siblings:_____

_____

Other:_____

_____

Briefly describe your childhood and adolescence (include home atmosphere, relationship with parents, etc):_____

_____

Any history of significant life events such as death, abuse, divorce, separation, etc? YES NO

Health Information:

Primary Physician:_____ Specialty:_____ Phone:_____

Other Physician:_____ Specialty:_____ Phone:_____

Other Physician:_____ Specialty:_____ Phone:_____

List any significant current health problems:_____

_____

List any significant health problems you have had in the past:_____

_____

List any significant family history of health problems :_____

_____

List any allergies you have or have had in the past:_____

_____

List any medications you are taking and the dosage:_____

_____

List any vitamins and supplements you are taking and the dosage:_____

_____

List any drug, alcohol, caffeine, and nicotine use (current and past):_____

_____

Any personal history of drug and/or alcohol abuse? YES NO

Any family history of drug and/or alcohol abuse? YES NO

Alternative health practices regularly engaged in (i.e., yoga, chiropractic, etc): _____

_____

Have you seen someone for psychological treatment before? YES NO

If yes, when and with whom?_____

_____

Give a brief description of treatment:_____

_____

List any significant family history of psychological problems :_____

_____

Additional Health Information (use space as necessary): _____

_____

_____

Referral Information:

How were you referred to Dr. Gillock? Self_____ Family/Friend_____ Health Professional _____

Online Service (i.e., Psychology Today)_____ Website _____ Other_____

If referred by a health professional, may I send a thank you note to that person?_____

Name and contact information: _____

_____

Briefly, what is the issue that prompted this referral?_____

_____

_____

CONSENT TO RELEASE & EXCHANGE INFORMATION FOR CLINICAL SERVICES

I want the following information shared for treatment planning and/or service coordination. By signing this form, I am allowing service providers or agencies to exchange information that will be useful in planning current treatment, and/or will make it easier for them to work together effectively in planning and/or providing services.

Patient's Full Name _____

Patient's Date of Birth _____ Patient's Social Security Number_____

My relationship to the Patient is: ☐ Self ☐ Parent ☐ Guardian

I want the following confidential information about the Patient to be exchanged:

☐ Psychological/Psychiatric Assessment Information
☐ Psychological/Psychiatric Treatment Records
☐ Synopsis of Psychological/Psychiatric Treatment
☐ Psychological/Psychiatric Diagnosis
☐ Educational/Criminal Justice Records/Files
☐ Medical Assessment Information
☐ Medical Treatment Records
☐ Synopsis of Medical Treatment
☐ Medical Diagnosis
☐ Other _____

I want Dr. Karen Gillock and the following service providers or agencies to exchange this information: (Please fill in names and telephone numbers/email addresses.)

☐ Primary Care Physician/Nurse/Assistant_____

☐ Specialty Physician/Nurse/Assistant_____

☐ Psychologist/Therapist/Counselor_____

☐ Psychiatrist/Psychiatric Nurse_____

☐ Hospital/Inpatient Facility_____

☐ Partial Hospital Program_____

☐ Other _____

I want information to be shared in the following form (check all that apply; typically check all three):

☐ Written Information ☐ In Meetings or by Telephone ☐ Computerized Data

I want to share additional information received after this consent is signed: ☐ Yes ☐ No

This consent is good until 1 year from the date signed

I can withdraw this consent at any time by telling the referring agency. This will stop the listed parties from sharing information after they know my consent has been withdrawn. I have the right to know what information has been shared, and why, when, and with who it was shared. If I ask, each party will provide me with this information. I want the parties listed above to accept a copy of this form as consent to share information.

Signature _____ Date Signed_____