CLIENT REGISTRATION FORM

Date: _____

Print Full Name: _____

Date of Birth: _____ Age:_____

-Relationship Status (circle):
Single/Committed Relationship/Married/Separated/Divorced/Widowed/Other:

-Employment Status (circle):
Employed(FT)/Employed(PT)/Student(FT)/Student(PT)/Unemployed/Household Manager/Military(branch):_____/Retired/Other:_____

-Occupation(s)/Major(s):_____

-Employer/School:_____

-Parenting Status: Do you have children? Yes:_____ No:_____
If yes, please list names, ages, and living arrangements:

Contact Information

Current Address (Street, City, State, Zip Code):

_____

_____

Mailing/Permanent Address (if different than above):

_____

_____

Email Address:_____

Home Phone Number: _____ Okay to leave msg? Yes___ No____

Cell Phone Number :_____ Okay to leave msg? Yes___ No____

Work Phone Number :_____ Okay to leave msg? Yes___ No____

Emergency Contact Information

Name _____ Relationship to you _____

Home Phone _____Cell Phone _____

Address (Street, City, State, Zip Code) _____

_____

Primary Care Physician: Name:_____

Address:_____

Phone:_____ Fax:_____

Psychiatrist/Prescriber: Name:_____

Address:_____

Phone:_____ Fax:_____

Current Medications/Supplements:

-How were you referred to Integrative Psychology?

____ By a friend/relative/co-worker

_____By a mental health provider:_____

_____By a medical provider:_____

_____Psychology Today

_____Web search

_____Other:_____

INSURANCE AND PAYMENT INFORMATION

Insurance Company Name:_____

Policy Holder's Name:_____Relationship toClient:_____

Policy Holder's Birthday:_____Policy Holder's Phone:_____

Policy Holder's Address:_____

_____

Policy Holder's Employer:_____Policy Holder's Insurance ID #:_____

Client's Insurance ID (if different):_____Group # and/or Plan Name:_____

Insurance Company Contact Phone # (for behavioral or mental health services, if listed):

_____

BENEFIT INFORMATION (IF KNOWN):

-Prior Authorization Required? __Y __N # of sessions approved initially:_____ (Auth. #_____)

-Plan coverage is:_____% Co-Pay is $_____per session.

-Plan has a deductible of: $_____ and requires out-of-pocket expenses of $_____

-Benefits renew on:_____ Have benefits been exceeded for current year?(Y/N)_____

Confidentiality Statement:I understand that all information contained in my clinical record is confidential. Those who can access my record are Sarah Gray, Psy.D. and her administrative/billing staff, as well as myself. All others will require written permission from me to access my clinical record.

Patient Balance Agreement: I understand that if Sarah Gray, Psy.D. sends invoices to my private insurance company*, I am responsible for any portion of the charges not paid by my insurance*.I understand that the payment terms of any such balance are due upon receipt of statement.

Authorization to Release Information: I authorize Sarah Gray, Psy.D. to release and obtain all information necessary to secure payment of any insurance benefits and for the purposes of processing my insurance claims.

Authorization of Benefits: I authorize and request my insurance company to pay directly to Sarah Gray, Psy.D. all benefits, including the right for services rendered to me.

I have been given a copy of my rights and responsibilities, which I fully understand and agree with.

_____ _____ _____

Signature of Client Printed Name Date

PSYCHOLOGIST-CLIENT SERVICES AGREEMENT

(Integrative Psychology and Behavioral Medicine)

Welcome to Integrative Psychology and Behavioral Medicine. This document (the Agreement) contains important information about our professional services and business policies.

Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time.

When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular problems you are experiencing. There are many different methods I may use to help with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. ***In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.***

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs and of my ability to provide the most appropriate treatment given these needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work might include and a recommended initial treatment plan, if you decide to continue with therapy.

You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a commitment and investment of time, energy, and financial resources so you should be very thoughtful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion or to make referrals for others who may be a better fit depending on your needs and preferences.

CONTACTING ME

Due to my work schedule, I am often not immediately available by phone, as I generally will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by

voicemail, which I monitor daily between Monday and Friday. If you leave me a voicemail on a weekday, I will make every effort to return your call within 48 hours. If you are difficult to reach, please inform me of some times when you will be available. You should also be aware that I am not often able to check voicemail after 5pm on weekdays, nor on weekends or holidays.
In the event of a clinical emergency or if you feel unsafe, if you are unable to reach me and feel that you cannot wait for me to return your call, you should call 911 and/or proceed to your nearest emergency room, where psychiatric emergencies services should be available. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

MEETINGS

I normally conduct an evaluation that will last from 1 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals.

Once psychotherapy has begun, we will usually schedule 50 minute sessions (one appointment hour of about 50 minutes duration) which will usually occur weekly or every other week, although some sessions may be longer or more frequent.

Once an appointment hour is scheduled, that time is reserved specifically for you. Therefore, you will be expected to pay for it unless you provide **24** hours advance notice of cancellation unless we both agree that you were unable to attend due to unusual circumstances beyond your control. **If you cancel with less than 24 hours or if you fail to show for your appointment, you will automatically be charged a fee of $125.00 to the credit card on file for you. It is important to note that insurance companies do not provide reimbursement for cancelled or missed sessions, so you will be personally responsible for payment of sessions for which you do not provide 24 hours advanced notice of cancellation.**

In order to best protect your right to privacy and confidentiality, if I see you outside of a session, e.g. on the street or in a public place, I will not acknowledge you unless you acknowledge me first. If you do choose to acknowledge me, please note that I will not engage in discussions related to your treatment.

PROFESSIONAL FEES

My hourly fee for our 2 initial meetings (CPT 90791) is $275.00. Thereafter, the fee for additional psychotherapy sessions is $250.00 for 38-52 minutes (90834, as set by 2013 CPT billing codes) or $250.00 for 53-60 minutes (90837, as set by 2013 CPT billing codes) unless another fee arrangement has been agreed to in advance. In addition to regularly-scheduled appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. My fee for all time spent related to legal proceedings is $250.00 per hour.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held (i.e., at the time services are rendered), unless you have insurance coverage that requires another arrangement or we agree otherwise in advance. This policy also applies to payment of insurance co-pays and deductibles, if applicable. A $10.00 service charge will be charged for any checks returned for any reason for special handling.

Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is her/his name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and EPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to suggest other providers who can help you continue with your psychotherapy.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis beginning at the first visit. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information

databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

LIMITS ON CONFIDENTIALITY

Please see HIPAA document.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I may keep Protected Health Information about you in two sets of professional records. The set of records which I am *required* to maintain constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. You may examine and/or receive a copy of your Clinical Record if you request it in writing unless I believe that access would endanger you. In those situations, you have a right to a summary and to have your record sent to another mental health provider or your attorney. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee of no more than 50 cents per page for the each of the first 100 pages of the medical record and no more than 25 cents per page for each page in excess of 100 pages. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon your request.

In addition, I *may* also keep a set of Psychotherapy Notes. These Notes, should I choose to maintain them, are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes unless I determine that it would adversely affect your well-being, in which case you have a right to a summary and to have your record sent to another mental health provider or your attorney.

MINORS AND PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records, unless I believe this review would be harmful to the patient and his/her treatment. Because privacy in psychotherapy is often crucial

to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you at your request. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

CHECKING THE BOX BELOW INDICATES THAT YOU HAVE READ THE INFORMATION IN THIS PSYCHOLOGIST-CLIENT AGREEMENT AND AGREE TO ABIDE BY ITS TERMS FOR THE DURATION OF OUR PROFESSIONAL RELATIONSHIP.

_____ _____ _____

Check Signature Date

_____

Printed Name

E-Mail, Texting, Social Media and Telemedicine Policy

Email and/or texting communication between therapist and clients may be useful, but will only be practiced if you give consent, as there are important privacy/confidentiality issues that arise. Please read through the following questions to determine whether or not you would like to consent to use of email and/or texting during the course of our work.

Q. Is my clinician required to use e-mail and/or texting with me?
No. Both you and your clinician(s) must agree to use e-mail and/or texting. Not everyone is comfortable using e-mail and/or texting, and there may be times when your clinician feels that e-mail and/or texting is not the best way to communicate.

Q. How confidential is e-mail and/or texting between us?
We treat your e-mail and/or texts with the same high level of confidentiality as your other medical information. However, messages must travel (unencrypted) over the Internet or via cellular signals, and there is a remote possibility that a message could be intercepted by a third party. If you use your office e-mail to communicate with us, it is also possible that your employer may read your message as part of routine monitoring of employee e-mail usage. If you use texting to communicate and do not delete the texts, it is possible that others could read those texts if they have access to your phone.

Q. How quickly will my clinician reply to my e-mail and/or texts?
We monitor email and/or texts at least once per day during the work week, Monday through Friday from 9am-5pm. You should receive a reply within two working days (Monday through Friday), unless we are out of the office for a period of time for vacation or another reason. Please anticipate that it is unlikely that we will respond to email and/or texts over the weekend, on holidays, or after business hours but will attend to your message during the work week. Please note that we do not allow texts after 9pm.

We generally find it most helpful for us to discuss your experiences and questions in person during our sessions. You may find it helpful to share certain things with us throughout the week, or have logistical questions that arise between sessions. You are welcome to email us your thoughts, experiences and questions between sessions. Please note that we will respond to clinical material in person and often will respond email by letting you know that we have received and read your message and will look forward to discussing the content in person. In general, texts are acceptable only for quick messages related to scheduling matters.

Q. Are e-mail and/or text messages placed in my medical record?
Yes, unless the subject matter is simply about appointment scheduling, the content of each e-mail and/or text message exchanged between us will become part of your medical record.

Q. I need to speak with my clinician today for urgent communication. Can I use e-mail and/or texting for this?
No, please do NOT use e-mail and/or texting for urgent communication or crisis needs. Always use the telephone when you need to be in touch more urgently; we do our best to respond to phone calls within 48-hours during the work week. If you are in crisis and need clinical attention immediately, please report to the nearest emergency room and/or call 911, and feel free to call to let your clinician(s) know you've done so from the emergency room.

Q. Are there some topics that I should avoid in e-mail and/or text messages?
You should not discuss the following topics via e-mail and/or texts: mental health diagnoses (including sexual assault and domestic violence); sexually transmitted diseases, HIV/AIDS, alcohol and drug treatment, and abortion.

Q. May I request, reschedule, or cancel an appointment with you via e-mail and/or text?
Yes, unless the request is very time sensitive. Remember, it may take two working days to receive a reply. You may also use our secure, HIPAA-compliant online scheduling tool via your Simple Practice client portal, if you have activated this benefit. It can be found at: https://drsarahgray.clientsecure.me.

Q. Can I stop using e-mail and/or texting with my clinician?
Yes, you may stop using e-mail and/or texting at any time by providing a written request to us.

Q. What about social media?
Due to the importance of your confidentiality and the importance of minimizing dual relationships, we do not accept friend or contact requests from current or former clients on any social networking site (Facebook, Twitter, LinkedIn, etc.). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Following
You may "like" or "follow" Integrative Psychology and Behavioral Medicine's Facebook and/or Twitter business pages. However, if you like/follow these pages, you are choosing to reveal that you are connected to the practice in some way. Integrative Psychology and Behavioral Medicine's business pages exist to be a forum of information and inspiration for the general public, so if you are comfortable with others you know online seeing that you are connected to a psychology page, you may choose to follow/like for informational purposes. Clinicians will not engage in conversations with you on that page and we will not follow you back in order to protect your privacy and maintain therapeutic boundaries. You are welcome to use your own discretion in choosing whether to follow the pages involving business blogs or newsletters. If there are things from your online life that you wish to share, please bring them into your sessions where you can view and explore them together with your clinician, during the therapy hour.

Q. What about telemedicine?

At this time, telemedicine is an evolving field with guidelines that vary from state to state. After much research, Integrative Psychology and Behavioral Medicine is excited to offer a secure, HIPAA-compliant telemedicine platform for established clients who may wish to use this option for sessions when they are traveling or if they have recently moved. Although some insurance plans are beginning to cover these sessions, many do not, so it is important to check coverage and discuss the parameters for the use of this therapeutic tool with your clinician.

Email and/or Texting Informed Consent

In order to communicate with you by email and/or texting, we need to make sure you are aware of the confidentiality and other issues that arise when we communicate this way and to document that you are aware of these and agree to them. Please sign the form below and return it to your Integrative Psychology and Behavioral Medicine clinician either in person or via the secure client portal:

I understand that all e-mail and/or text messages are sent over the Internet or via cell phone networks and are not encrypted, are not secure, and will NOT be encrypted and, therefore, my Integrative Psychology and Behavioral Medicine clinician(s) cannot guarantee the confidentiality and security of any information sent to her/him or that she/he may send to me/my child via e-mail and/or text.

We have also discussed Integrative Psychology and Behavioral Medicine's guidelines for the use of e-mail and/or texting and social media and I understand and agree to the parameters stated in those guidelines. I have read and understand the Frequently Asked Questions sheet regarding the use of e-mail and/or texting and social media.

I hereby give permission for my clinician(s) and/or administrative staff at Integrative Psychology and Behavioral Medicine to reply to my/my child's messages via emails and/or texting including any information that she/he deems appropriate, that would otherwise be considered confidential. I agree that clinicians at Integrative Psychology and Behavioral Medicine shall not be liable for any breach of confidentiality that may result from this use of e-mail via the Internet and/or text messages via cellular networks. I understand that neither email nor text communication should be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. If I believe I need a response within 48 hours, I will not use e-mail and/or texting but will call. If I do not receive an answer to a routine email and/or text message within two working days, I understand that I should call. I understand that all e-mail and/or text communications may be made part of my/my child's permanent medical record. I also understand that I may withdraw permission to communicate with me via e-mail and/or texting via written notification.

I hereby give the staff/clinician(s) permission to e-mail me/my child at the following e-mail
address(es):_____
_____

I hereby give permission for staff/clinician(s) to text me/my child at the following number(s):

_____
_____

_____

Client's Signature Date

_____

Parent/guardian's Signature (if client is a minor): Date

Notice of Psychologists' Policies and Practices to

Protect the Privacy of Your Health Information

(HIPPA Notice of Privacy Practices)

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

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

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 [office, clinic, practice group, etc.], such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], 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. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation 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 I, in my professional capacity, have reasonable cause to believe that a minor child is suffering physical or emotional injury resulting from abuse inflicted upon him or her which causes harm or substantial risk of harm to the child's health or welfare (including sexual abuse), or from neglect, including malnutrition, I must immediately report such condition to the Massachusetts Department of Children and Family Services (formerly the Department of Social Services.
- **Adult Abuse:** If I have reasonable cause to believe that an elderly person (age 60 or older) is suffering from or has died as a result of abuse (including financial exploitation), I must immediately make a report to the Massachusetts Department of Elder Affairs. I must make a report to the Disabled Persons Protection Commission and/or other appropriate agencies, if I have reasonable cause to believe that a mentally or physically disabled person is suffering from or has died as a result of a reportable condition, which includes non-consensual sexual activity (see below). I need not report abuse if you are a disabled person and you invoke the psychotherapist-patient privilege to maintain confidential communications.
- **Health Oversight:** The Board of Registration of Psychologists has the power, when necessary, to subpoena relevant records should I be 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 your diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release information without written authorization from you or your legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** If you communicate to me an explicit threat to kill or inflict serious bodily injury upon an identified person and you have the apparent intent and ability to carry out the threat, I must take reasonable precautions. Reasonable precautions may include warning the potential victim, notifying law enforcement, or arranging for your hospitalization. I must also do so if I know you have a history of physical violence and I believe there is a clear and present danger that you will attempt to kill or inflict bodily injury upon an identified person. Furthermore, if you present a clear and present danger to yourself and refuse to accept further appropriate treatment, and I have a reasonable basis to believe that you can be committed to a hospital, I must seek said commitment and may contact members of your family or other individuals if it would assist in protecting you.
- **Worker's Compensation:** If you file a workers' compensation claim, your records relevant to that claim will not be confidential to entities such as your employer, the insurer and the Division of Worker's Compensation.

There may be additional disclosures of PHI that I am required or permitted by law to make without your consent or authorization, however the disclosures listed above are the most common.

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 and psychotherapy notes 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 am required by law to notify you as soon as possible if a probable breach of sensitive Protected Health Information (PHI) occurs.
- I will not sell nor share your information to anyone for any reason outside of the previously-stated limits of confidentiality (billing purposes, life-threatening emergencies, abuse of protected populations, e.g.).
- You may request that I do not notify your insurer about health services you are paying for out of pocket.
- 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 provide you with a revised notice either in person or by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at 339-707-5236.

If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to me at: Integrative Psychology and Behavioral Medicine, 366 Massachusetts Avenue, Suite 303, Arlington, MA, 02474.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon 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 September 23, 2013.

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. I will provide you with a revised notice either in person or by mail.

Acknowledgement of Receipt of Notice of Privacy Practices

This form, when completed and signed by you, indicates that you

1) have received a copy of the Notice of Privacy Practices entitled "Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information,"

2) have read the notice, and

3) will request additional information if you do not fully understand the information contained therein.

I, _____ acknowledge receipt of the above referenced notice and agree to the terms and conditions outlined above.

I received this notice on _____(mm/dd/yyyy).

_____ _____

Signature of Client Date Signed

Authorization for Release of Confidential Records and Information

Client Name _____ Date of Birth _____

Address (Street, City, State, Zip) _____ Phone _____

_____

●I (client), _____, hereby authorize:

Person(s)/organization(s) and contact info:

_____
_____
_____

to ❑ speak to / correspond with and/or ❑ release medical records to Sarah Gray, Psy.D. regarding my medical and/or mental health treatment. This release of information/records is for the purposes of ongoing mental health assessment, evaluation, and/or treatment. Please forward the records released herein to the address in the letterhead at the top of this form.

●I also hereby authorize Sarah Gray, Psy.D. to ❑ speak to / ❑ correspond with_____
_____
_____
_____
_____
and/or ❑ release clinical records regarding my mental health treatment in her practice.

●*I also specifically authorize the release of* ❑*information and/or* ❑*medical records related to:*

- alcohol and drug abuse diagnosis and treatment

  _____
  Client Signature

Date

- AIDS/ARC and/or HIV testing results and treatment

  _____
  Client Signature

  Date

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of

the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my

part. This authorization will be valid from the date of signature or until _____. I understand that I may withdraw this authorization at any time , except to the extent that action based on this authorization has already been taken.

_____ _____

_____

Signature of Patient/Client Printed Name

Date