Susan Kelsey, LMFT, RPT-S
Licensed Marriage & Family Therapist/Registered Play Therapist-Supervisor
381 Earhart Way, Livermore, CA 94551
(800) 890-1962 / susan@fremontchildtherapy.com

CLIENT INFORMATION – CHILD

Child's Name: _____ Date of Birth: ____/_____/_____

Address: _____

City: _____ Zip Code: _____

Telephone: ( ) _____

Child's Physician: _____ Phone: ( ) _____

School: _____ Grade in School: _____

Teacher's Name: _____

Names and Birth Dates of Siblings: _____

Primary reason(s) for seeking services (check all that apply):

_____ Alcohol/Drug use	_____ Anger problems	_____ Anxiety	_____ Compulsive behaviors
_____ Coping Problems	_____ Defiance	_____ Depression	_____ Eating problems
_____ Fears/Phobias	_____ Hyperactivity	_____ Inattention	_____ Mental confusion
_____ Mood swings	_____ No friends	_____ Poor social skills	_____ Poor grades
_____ Poor self-concept	_____ Sexual concerns or sexual acting out	_____ Sleeping problems	____ Suicidal thoughts/ threats/attempt(s)

Explain/Other _____

_____

Prior therapy or counseling: Date(s)_____ Therapist(s) _____

Is child on any medications at this time? Medication/Dosage: _____

Is there a family history of mental disorders/depression/autism, etc.? Explain:_____

_____

Who referred you to our office? _____

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PARENT INFORMATION

Parent/Guardian: _____ Birthdate: _____

Address: _____

City: _____ Zip Code: _____

Home Phone: ( ) _____ Email: _____

Occupation/Place of Employment: _____

Work#: ( ) _____ Cell #: ( ) _____

Of all of the methods given above, is there a method you DO NOT wish to be contacted? _____

Parent/Guardian: _____ Birthdate: _____

Address: _____

City: _____ Zip Code: _____

Home Phone: ( ) _____ Email: _____

Occupation/Place of Employment: _____

Work#: ( ) _____ Cell #: ( ) _____

Of all of the methods given above, is there a method you DO NOT wish to be contacted? _____

Child's Parents Are: _____ Married; _____ Divorced; _____ Separated; _____ Never Married

_____ Child was adopted (at age _____); Other (explain) _____

If divorced, who has ***legal*** custody? _____With whom does the child live at this time? _____

Is there any significant information about the parents' current relationship that may be affecting the child's behavior?

_____

Have there been any stressful events in the child's life in the last 18 months? (i.e. moves, deaths, injuries, etc.) _____ If yes,

please explain: _____

I GIVE MY CONSENT FOR THERAPY FOR MY CHILD:

Signed: _____ _____

Parent or Legal Guardian Other Parent (if consent required by both parents)

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OFFICE POLICIES/CLIENTS RIGHTS

PAYMENT FOR SERVICES: The session fee is $250. Sessions last for approximately 40-50 minutes depending upon age and maturity level of the child. Families are expected to pay for services at the **beginning** of each session. You may pay via cash, check or credit card. Returned checks are assessed a $25 service fee. The session fee includes brief summaries for insurance companies and brief telephone consultations between sessions if necessary. Telephone consultations that exceed 5 minutes, extensive report writing, school observation, or other types of out of office sessions will be charged at the regular session fee of $250 per 45 minutes.

INSURANCE REIMBURSEMENT: Professional services are rendered and charged to the client. I am happy to submit insurance information to your insurance company monthly. Please be aware that if our office is requested to provide information directly to an insurance company regarding your treatment**, the information released may be highly confidential**. More details will be provided on request.

CONFIDENTIALITY: Clients (including children) have the right to a confidential relationship with their therapist, therefore all information disclosed in session is confidential and may not be revealed to anyone without written permission (except where disclosure is permitted or required by law). Disclosure may be required under the following circumstances: Where there is reasonable suspicion of child or elder abuse; where there is reasonable suspicion that the client presents a danger of violence to others or where the client is likely to harm him or herself unless protective measures are taken. Disclosure may also be required pursuant to a legal proceeding. Some information is shared among professional associates for purposes of training or collaboration to assist in treatment.

INITIAL CONTACT: Our first appointment is often called an "initial evaluation." This appointment is scheduled for you to discuss your concerns and problems. It is also a time to obtain historical and background information. In times of crisis, however, the usual format of an initial evaluation may be postponed in the hope that the time might be used to relieve and resolve the immediate crisis. Given a crisis situation, the background information may be gathered at subsequent sessions.

OTHER PSYCHOLOGICAL SERVICES: At times, a client's distress remains or becomes high and the use of medication or hospitalization must be considered. Therapists are not physicians. Consequently, they do not prescribe medication. In cases where medication or hospitalization may be required, this will (when possible) be discussed in advance with the client and with other responsible individuals (if necessary). We collaborate with physicians on issues of medication and hospitalization.

MESSAGES: As we work together you will notice that telephone calls are not usually accepted during session. If you are in the waiting room during your child's session and an emergency arises, you may ring your therapist's bell to notify her of the urgent situation. Otherwise, during sessions and at other times during the day or evening, messages may be left on voice mail. Calls will be returned as soon as possible. **IF YOU ARE EXPERIENCING AN EMERGENCY, CALL 911.**

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OFFICE POLICIES/CLIENTS RIGHTS (cont.)

CHILDREN IN TREATMENT: When in-person therapy is resumed, parents are expected to bring their child to treatment personally (unless arranged in advance with therapist) and must stay in the waiting room or immediate area during the session. This enables parents to participate in treatment or help subdue a child who is out of control if necessary. Parents are also expected to be on hand to take a child to the rest room during session. In regard to information disclosed by your child in session, it is important that your child is able to trust the process completely. Therefore, such information will be kept confidential in the same way that confidentiality is maintained for an adult (see the "Confidentiality" section above for details). As the parent or guardian, you have the right and responsibility to question and understand the nature of the therapist's activities and progress with your child. The therapist will use clinical discretion as to what is appropriate to disclose. When services are provided virtually via telehealth, it is best to provide your child a quiet, private space so that your child can be open and honest and not feel overheard.

TREATMENT/CLIENT'S RIGHTS: You are expected and encouraged to obtain knowledge of the procedures, goals, and possible effects of psychotherapy on your child or adolescent. We expect to make our contact one where your child or adolescent receives the maximum benefit. Participation in therapy can result in a better understanding of one's personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek treatment for your family. Working toward these benefits, however, requires effort and may result in your child or adolescent taking some risks. The risks may include experiencing feelings including sadness, anger, fear, guilt, or anxiety. It is important to remember that these may be natural and normal and are an important part of the therapy process. At any time, clients may question and/or refuse therapeutic or diagnostic procedures or methods, and parents can request whatever information they may wish to know about the process and course of therapy. Complaints regarding psychotherapy services can be filed at the California Board of Behavioral Sciences (bbs.ca.gov).

TERMINATION: Termination of psychotherapy may occur any time and may be initiated by either the client or the therapist. We request that if a decision is being made to terminate, there be a minimum of seven days notice in order that a final termination session (or sessions) may be scheduled to explore the reasons for termination. Termination itself can be a constructive, useful process. If any referral is warranted, it will be made at that time.

EXPECTATIONS OF CLIENTS: All clients are expected to behave appropriately while they are receiving services in the office. This includes: respecting the privacy and confidentiality of others; being quiet in the waiting room, and helping to maintain a neat, clean, and safe waiting room and therapeutic environment.

THANK YOU FOR YOUR COOPERATION AND ENTRUSTING US WITH YOUR FAMILY'S PSYCHOLOGICAL CARE.

Signature below indicates acknowledgement and acceptance of these office policies/client rights:

_____ _____

Client or Parent/Guardian Date

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POLICY ON MISSED APPOINTMENTS

Due to the fact that many more people request psychological services than we are able to provide, we have adopted the following policies to ensure that our time is used to its broadest extent.

Please read and initial your acknowledgment and acceptance of the following:

(initial) _____ As the scheduling of an appointment involves the reservation of time specifically for you, we will accept cancellation or rescheduling made **at least 24 hours prior to a scheduled appointment.** If your child is ill, I would be happy to use the time for a telephone consultation with parents. Please do not bring sick children to therapy.

(initial) _____ The full session fee ($250.00) is charged for late cancellation or no show appointments.

(initial) _____ It is important to note that insurance benefits DO NOT apply to late cancellation and no show charges. **The $250 session fee is solely YOUR responsibility**

Signature: _____

Print Name: _____

Date: _____

Relationship to Patient: _____

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CONSENT TO SHARE TEACHING EXAMPLES

I train therapists who are learning to work with children, and during my trainings I sometimes find it helpful to share samples of children's art or videos of children in play sessions so the student therapists can see how the strategies are implemented. To help insure confidentiality, I change details regarding the child so that the child and family can remain anonymous (for example, I might describe the case as a 4 year old child whom I saw 10 years ago, when actually it's a child I am seeing now). In addition, the therapists in the classes are bound by the same rules of confidentiality as we are in a client session which prevents them from sharing these details with anyone else. Participation is voluntary, so please mark your preference below if you would allow me to share samples of your child's work or session videos in these trainings. Thank you.

Child's Name: _____

My initials below indicate that I DO give my consent to allow samples of my child's art or play sessions to be used for teaching purposes in training workshops with other therapists. I understand that every effort will be made to keep my child/family's identity confidential.

I GIVE MY CONSENT***Initials _____

OR:

My initials below indicate that I DO NOT give my consent to allow samples of my child's art or play sessions to be used for teaching purposes in training workshops with other therapists.

I DO NOT GIVE MY CONSENT***Initials _____

Date: _____

Signature: _____

Print Name: _____

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Relationship to Child _____

BEHAVIORAL/EMOTIONAL

Please check any of the following that are typical for your child:

____ Affectionate
____ Aggressive
____ Alcohol use
____ Angry
____ Anxiety
____ Attachment to dolls
____ Avoids adults
____ Bedwetting
____ Blinking, jerking
____ Bizzare behavior
____ Bullies, threatens
____ Careless, reckless
____ Chest pains
____ Clumsy
____ Confident
____ Cooperative
____ Cyber addiction
____ Defiant
____ Depressed
____ Destructive
____ Difficulty speaking or mute
____ Dizziness
____ Drug use/dependence
____ Eating disorder or problems
____ Enthusiastic
____ Excessive masturbation
____ Expects failure
____ Fatigue
____ Fearful
____ Frequent injuries
_____Frustrated easily
_____Gambling
_____Generous
_____Hallucinations
_____Head banging
_____Heart problems
_____Hopelessness
_____Hurts animals
_____Imaginary friends
_____Impulsive
_____Irritable
_____Lazy
_____Learning problems
_____Lies frequently
_____Listens to reason
_____Loner
_____Low self-esteem
_____Messy
_____Moody
_____Nightmares
_____Obedient
_____Often sick
_____Oppositional
_____Over active
_____Over weight
_____Panic attacks
_____Phobias
_____Poor appetite
_____Psychiatric problems
_____Quarrels
_____Sad
_____Selfish
_____Separation anxiety
_____Sets fires
_____Sexual addition
_____Sexual acting out
_____Shares
_____Sick often
_____Short attention span
_____Shy, timid
_____Sleeping problems
_____Slow moving
_____Soiling
_____Speech problems
_____Steals
_____Stomachaches
_____Suicidal threats
_____Suicidal attempts
_____Talks back
_____Teeth grinding
_____Thumb sucking
_____Tics or twitching
_____Unsafe behaviors
_____Unusual thinking
_____Victim of bullying/teasing
_____Weight loss
_____Withdrawn
_____Worries excessively
_____Other: _____
_____

Please describe any of the above (or other) concerns: _____
_____
How are problem behaviors generally handled? _____
_____
What are the family's favorite activities? _____
_____
What does your child/adolescent do with unstructured time?_____
_____

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CHILDHOOD/ADOLESCENT HISTORY

Pregnancy/Birth:

Was the pregnancy planned? _____Yes _____ No Length of pregnancy: _____
Mother's age at child's birth: _____ Father's age at child's birth: _____
Child number _____ of _____ total children
How much weight did the mother gain during pregnancy? _____
While pregnant did the mother smoke? _____Yes _____ No If yes, what amount: _____
Did the mother use drugs/alcohol? _____Yes _____ No If yes, type/amount: _____ While pregnant, did the mother have any medical or emotional difficulties? (i.e. surgery, hypertension, medication, etc.) _____Yes _____ No If yes, please describe: _____
_____
_____
Length of labor: _____ Induced? _____Yes _____ No Caesarean? _____Yes _____ No
Baby's birth weight: _____ Baby's birth length: _____
Describe any physical or emotional complications with the delivery: _____
_____
Describe any complications for the mother or the baby after the birth: _____
_____
Length of hospitalization: Mother: _____ Baby: _____
Has the mother had any occurrences of miscarriages, stillborns, or loss of a child? _____Yes _____ No
If yes, describe: _____

Infant/Toddler: Check all that apply:

___ Breast fed	___ Milk allergies	___ Vomiting	___ Diarrhea
___ Bottle fed	___ Rashes	___ Colic	___ Constipation
___ Not cuddly	___ Cried often	___ Rarely cried	___ Overactive
___ Resisted solid food	___ Trouble sleeping	___ Irritable when awakened	___ Lethargic

Developmental History: Please indicate "E" for early, "A" for average, and "L" for late on the following:

Sat alone:	E	A	L	Dressed self:	E	A	L
Took 1st steps:	E	A	L	Tied shoe laces:	E	A	L
Spoke words:	E	A	L	Rode 2 wheel bike:	E	A	L
Spoke sentences:	E	A	L	Toilet trained:	E	A	L
Weaned:	E	A	L	Dry during day:	E	A	L
Fed self:	E	A	L	Dry during night:	E	A	L

Compared with others in the family, child's development was: _____ slow _____ average _____ fast

Age for following developments (fill in where applicable):
Began puberty: _____ Menstruation: _____
Voice changed: _____ Breast development: _____
Issues that affected child's development (e.g. physical/sexual abuse, inadequate nutrition, neglect, etc.)
_____
_____

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EDUCATION

Current school: _____ School phone number: _____
Type of school: _____Public _____Private _____Home Schooled _____Other: _____
Grade: _____ Teacher: _____ School Counselor: _____
In special education? _____Yes _____No If yes, describe: _____
In gifted program? _____Yes _____No If yes, describe: _____
Has child ever been held back in school? _____Yes _____No If yes, what year(s)? _____
Which subject(s) does the child enjoy in school: _____
Which subject(s) does the child dislike in school: _____
What grades does the child usually receive in school? _____
Has there been any recent changes in grades? _____Yes _____No If yes, describe: _____
Has the child been tested psychologically? _____Yes _____No
If yes, describe: _____

Check the descriptions which specifically relate to your child:

Feelings about School Work:

___Anxious ___Passive ___Enthusiastic ___Fearful
___Eager ___No expression ___Bored ___Rebellious

Approach to School Work:

___Organized ___Industrious ___Responsible ___Interested
___Self-directed ___No initiative ___Refuses ___Does only what is expected
___Sloppy ___Disorganized ___Cooperative ___Doesn't complete assignments
___Other (describe): _____

Performance in School (Parent's Opinion):

___Satisfactory ___Underachiever ___Overachiever
___Other (describe) _____

Child's Peer Relationships:

___Spontaneous ___Follower ___Leader ___Difficulty making friends
___ Makes friends easily ___Shares easily ___ Long time friends ___Apathetic about friendships
___Other (describe): _____

Who handles responsibility for your child in the following areas?

School: ___Mother ___Father ___Shared ___Other _____
Health: ___Mother ___Father ___Shared ___Other _____
Problem Behavior: ___Mother ___Father ___Shared ___Other _____

If the child is involved in a vocational program or works a job, please fill in the following:

What is the child's attitude toward work? ___Poor ___Average ___Good ___Excellent

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Social Media Policy

This document outlines my office policies related to use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet. If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

FRIENDING

I do not accept friend or contact requests from current or former clients or their parents on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective 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.

INTERACTING

Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact me between sessions, the best way to do so is by phone at 800-890-1962. Direct email at susankelseymft@gmail.com is second best for quick, administrative issues such as changing appointment times. See the email section below for more information regarding email interactions.

GOOGLE READER

I do not follow current or former clients on Google Reader and I do not use Google Reader to share articles. If there are things you want to share with me that you feel are relevant to your treatment whether they are news items or things you have created, I encourage you to bring these items of interest into our sessions.

EMAIL

I prefer using email only to arrange or modify appointments. Email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

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My Private Practice Social Media Policy (cont.)

BUSINESS REVIEW SITES

You may find my therapy practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client, as it is **unethical for therapists to solicit testimonials**. Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it. If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that your family is in therapy with me wherever and with whomever you like. Confidentiality means that I cannot tell people that you are my client and I am prohibited from requesting testimonials. But you are more than welcome to tell anyone you wish that I'm your therapist or how you feel about the treatment I provided to you, in any forum of your choosing. If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum. I urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.

LOCATION-BASED SERVICES

If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally "checking in," from my office or if you have a passive LBS app enabled on your phone.

CONCLUSION

Thank you for taking the time to review my Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to my attention so that we can discuss them.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given to you (which follow this page). My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at [insert telephone number].
If you have any questions about my Notice of Privacy Practices, please contact me at: [insert address and telephone number].

I acknowledge receipt of the Notice of Privacy Practices of Susan Kelsey, MFT, RPT-S:

Signature: _____Date: _____
(patient/parent/conservator/guardian)

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Notice of Privacy Practices

I. 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.

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website (if applicable). You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website, which is located at (insert website address, if applicable).

III. HOW I MAY USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

1. For Treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

2. To Obtain Payment for Treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

3. For Health Care Operations. I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

4. Patient Incapacitation or Emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state, or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.
2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.
3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.
4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.

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Notice of Privacy Practices (cont.)

5. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.
6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.
7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.
8. To remind you about appointments and to inform you of health-related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.
1. Disclosures to Family, Friends, or Others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI
You have the following rights with respect to your PHI:

A. The Right to Request Restrictions on My Uses and Disclosures. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legal-lee required to make.

B. The Right to Choose How I Send PHI to You. You have the right to request that I send confidential information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. The Right to Inspect and Receive a Copy of Your PHI. In most cases, you have the right to inspect and receive a copy of the PHI that I that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.
If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Receive a List of the Disclosures I Have Made. You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before April 14, 2003.

Susan Kelsey, LMFT, RPT-S
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Notice of Privacy Practices (cont.)

I will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I may charge you a reasonable, cost-based fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The Right to Receive a Paper Copy of this Notice. You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section Vl below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: susankelseymft@gmail.com.

Vll. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.