

Family Enrichment Services
8800 49th Street N. Suite 212 ♦ Pinellas Park, FL 33782
Fax: (727) 865-5178

**Counseling
Documentation Checklist**

| Please check or mark N/A | Document Title * Requires signature of legal guardian |
|-----------------------------|--|
| | Referral Form (please e-mail or fax before sending documentation listed below) |
| | * Consent for Treatment |
| | * Rights and Responsibilities/Privacy Practices Acknowledgment |
| | * Medicaid Payment Agreement |
| | * After Hours-Supervision Agreement |
| | * Reciprocal Authorization to Release Information - CBC |
| | * Reciprocal Authorization to Release/Obtain Information for Primary Care Physician |
| | * Any other Authorization to Release/Obtain Information (for other previous or currently involved parties such as school or other treatment providers, as needed/relevant) |
| | Predisposition or Action Summary |
| | Case Plan |
| | Comprehensive Behavioral Health Assessment |
| | Psychological Evaluation(s) (if applicable) |
| | Psychiatric Evaluation(s) (if applicable) |
| | Other relevant documents |

Please deliver or mail all documents to:
Family Enrichment Services
8800 49th Street N. Suite 212
Pinellas Park, FL 33782
(727) 657-7761

Family Enrichment Services
8800 49th Street N. Suite 212 ♦ Pinellas Park, FL 33782
Fax: (727) 865-5178

CONSENT FOR TREATMENT

| | | | |
|--------------------|--|----------------------|--|
| CLIENT NAME | | DATE OF BIRTH | |
|--------------------|--|----------------------|--|

I, the undersigned, a Parent, Legal Guardian, or Authorized Representative of the client named above, authorize Family Enrichment Services to provide treatment as it pertains to assessment, treatment planning, monitoring, counseling, crisis intervention and other mental health services as needed.

- Assessment includes the collection of data and observations to provide a diagnosis, determine the strengths and needs of the child and family, and determine the modality of treatment that will best serve the individual needs of the child and family.
- Treatment planning includes collaboration with the child and family to determine treatment goals and measurable behavioral objectives that will be addressed during the course of treatment.
- Ongoing monitoring of the counseling process and outcome are also crucial elements of treatment.
- Individual and family counseling services address the emotional and/or behavioral symptoms that were the cause for initiation of treatment.
- Crisis intervention services are offered when there is a need for additional counseling or support services between regularly scheduled appointments.

The mental health treatment of children is sought for a variety of reasons. Among these is the desire to help children with emotional difficulties improve their interpersonal relationships, modify undesirable behavior, improve social functioning, improve academic achievement, and successfully live in the community.

Common positive side effects of mental health treatment are a decrease of symptoms and behaviors for which therapy was sought, increased feelings of personal well-being, improvement in interpersonal relationships, and improved social functioning. Common negative side effects include a temporary increase in symptomatic behavior while change is taking place and a lack of desire to continue treatment. These negative side effects can typically be overcome as long as there is a desire and motivation for change.

Mental health treatment modalities include, but are not limited to, the following:

- Interpersonal therapies (Humanistic, Gestalt, Transactional Analysis)
- Cognitive-Behavioral Therapies (Rational Emotive Behavioral Therapy)
- Other Psychotherapies (Humanistic, Solution-Focused, Narrative)
- Marriage and Family Therapies (Systemic, Structural, Strategic)

Approximate length of treatment is dependent on the modality used, the severity of the symptoms and the length of time the symptoms have been present, among other factors. On average, treatment lasts from six months to one year.

I understand that this consent can be revoked orally or in writing at any time during treatment. No guarantee or assurance has been made to me as to the results that may be obtained. I have read and fully understand this Consent for Treatment.

 Signature of Client (If minor, Parent and/or Legal Guardian/Authorized Representative must also sign)

 Date

 Signature of Parent / Legal Guardian / Authorized Representative (circle all that apply)

 Date

 Signature of Parent / Legal Guardian / Authorized Representative (circle all that apply)

 Date

 Signature of Counselor / Witness

 Date

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**CLIENT RIGHTS AND RESPONSIBILITIES &
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

| | | | |
|--------------------|--|----------------------|--|
| CLIENT NAME | | DATE OF BIRTH | |
|--------------------|--|----------------------|--|

I am acknowledging that I have been given adequate opportunity to read/review and understand the following documents:

- Client Rights and Responsibilities
- Notice of Privacy Practices

I understand that my protected health information contained within the designated record set may be used and/or be disclosed for purposes of carrying out treatment, obtaining payment, and carrying out other administrative operations of the organization.

I acknowledge that I

- have received a copy of these documents
- am not requesting a copy of these documents at this time

I understand that I may request a copy of these documents at any point in treatment.

I also understand that my signature does not mean that I have read these documents in their entirety or that I agree with them. By signing below, I hereby voluntarily and knowingly consent to allow Family Enrichment Services and any of its physicians, counselors, employees and/or agents, to use and/or disclose my protected health information as deemed appropriate to carry out treatment, payment and/or other administrative operations of the organization.

Signature of Client (If minor, Parent and/or Legal Guardian/Authorized Representative must also sign)

Date

Signature of Parent / Legal Guardian / Authorized Representative (circle all that apply)

Date

Signature of Parent / Legal Guardian / Authorized Representative (circle all that apply)

Date

Signature of Counselor / Witness

Date

Family Enrichment Services
8800 49th Street N. Suite 212 ♦ Pinellas Park, FL 33782
Fax: (727) 213-9054

MEDICAID PAYMENT AGREEMENT / AUTHORIZATION

| | |
|--------------------|----------------------|
| CLIENT NAME | DATE OF BIRTH |
|--------------------|----------------------|

I, the undersigned, a parent and/or legal guardian or authorized representative of the client named above, understand that I am responsible to pay for any therapy services received that are not covered by Medicaid. I further understand that most Medicaid plans do not require any co-payment for therapy services. If there is any co-payment, it will be outlined below. I authorize payment of insurance benefits for therapy service to be made directly to: Family Enrichment Services

I agree to make every effort to keep all appointments scheduled. If I am late for my appointment, I understand that time might be lost from my session. If I am unable to keep an appointment, I agree to notify my treatment provider at least 24 hours in advance. I understand that missed appointments not cancelled within 24 hours prior to the scheduled appointment can be cause for services to be discontinued. This applies to any and all services received at the agency.

I understand that this authorization will continue to be in effect unless I revoke it in writing.

I will be paying \$ 0 co-payment at each session in accordance with my insurance plan.

Signature of Parent and/or Legal Guardian / Authorized Representative

Date

Signature of Parent and/or Legal Guardian / Authorized Representative

Date

Signature of Parent and/or Legal Guardian / Authorized Representative

Date

Signature of Counselor / Witness

Date

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AFTER HOURS-SUPERVISION AGREEMENT

| | | | |
|--------------------|--|----------------------|--|
| CLIENT NAME | | DATE OF BIRTH | |
|--------------------|--|----------------------|--|

Per Florida Statutes chapter 491 and Florida Administrative Code Rule Chapter 64B4 of the Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling, a Registered Mental Health Counselor Intern is required to work under the supervision of a qualified supervisor. All cases must be reviewed by the qualified supervisor. Under the provisions of Florida Statute chapter 491.0147, all communication between the client, the Registered Mental Health Counselor Intern, and the qualified supervisor (or any combination thereof) will be held in strict confidence unless you have given express written permission, a court order has been provided to request records or there is risk of harm to yourself or others (including child or elderly abuse). I understand that I can discuss any questions regarding the qualifications or any other requirements of the Registered Mental Health Counselor Intern with my counselor at any time during treatment.

I further understand that my case will be discussed with a qualified supervisor and that I can call (727) 657-7761 if I have any questions regarding the services I am receiving.

It is the policy of Family Enrichment Services to provide comprehensive services to clients, including crisis intervention services when necessary. While we will make every effort to plan and implement proactive interventions, we recognize that emergency situations arise and families will occasionally need assistance between regularly scheduled appointments.

Situations that warrant requests for emergency services include, but are not limited to, the following:

- Suicidal or homicidal threats
- Physical aggression
- Running away
- Medication error
- Self-injurious behavior

In any type of life threatening emergency, please call 911 immediately.

Please use discretion in making requests for emergency services. All non-emergency situations will be addressed on the next business day. By signing below, I am acknowledging that I have read and fully understand the After Hours Agreement.

Signature of Client (If minor, Parent and/or Legal Guardian/Authorized Representative must also sign) _____
Date

Signature of Parent / Legal Guardian / Authorized Representative (circle all that apply) _____
Date

Signature of Parent / Legal Guardian / Authorized Representative (circle all that apply) _____
Date

Signature of Counselor / Witness _____
Date

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AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

| | | | |
|--------------------|--|----------------------|--|
| CLIENT NAME | | DATE OF BIRTH | |
|--------------------|--|----------------------|--|

I am the individual named above
 a legal guardian/personal representative because the client is a minor, incapacitated or deceased

I give permission for Family Enrichment Services to:

- Release information to:
 Obtain information from:

| | | | |
|--------------------------------------|---|---------------------|--|
| NAME OF PERSON / ORGANIZATION | Child Welfare Community Based Care (List Agency): | PHONE NUMBER | |
|--------------------------------------|---|---------------------|--|

The specific information to be disclosed is:

| | | |
|--|---|---|
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Assessment (e.g., Biopsychosocial, Brief Behavioral Health Status, In-Depth) | <input type="checkbox"/> Communication <input type="checkbox"/> Phone <input type="checkbox"/> E-mail <input type="checkbox"/> Written |
| <input type="checkbox"/> Medication Record | <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Comprehensive Behavioral Health Assessment |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Treatment Summary | <input type="checkbox"/> Child Study |
| <input type="checkbox"/> Educational Information | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pre-Disposition/Action Summary |
| <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> Other (Specify): | <input type="checkbox"/> Court Records (including case plan, judicial reviews and court orders) |

FOR THE PURPOSE OF: Coordination of care Other (specify):

I hereby authorize the disclosure of protected health information about the individual named above. I understand that my records have a privileged and confidential status. I am waiving that status for the purpose contained in this authorization.

- I understand that I do not need to sign this form in order to obtain enrollment, eligibility, treatment or payment for services.
 - I understand that I have the right to refuse to sign this authorization and do not have to agree to authorize any use or disclosure.
 - I understand that I can revoke this authorization at any time upon written notification to the provider named above. I further understand that revocation will not apply to information that has already been used or disclosed.
 - I understand that I am authorizing the release of information from records whose confidentiality and privileged status is protected by Federal Regulations and Florida Statutes. However, the recipient of this information may not have to abide by the same federal and state privacy laws.
 - I understand that I have a right to receive a copy of this authorization once I have signed it or may ask for a copy at any time by contacting the provider named above.

This authorization is valid for: a single disclosure, up to ninety (90) days continuing disclosure for up to one year from the date of my signature as it appears below

 Signature of Client (If minor, Parent and/or Legal Guardian/Authorized Representative must also sign)

 Date

 Signature of Parent / Legal Guardian / Authorized Representative (circle all that apply)

 Date

 Signature of Parent / Legal Guardian / Authorized Representative (circle all that apply)

 Date

 Signature of Counselor / Witness

 Date

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AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

| | | | |
|--------------------|--|----------------------|--|
| CLIENT NAME | | DATE OF BIRTH | |
|--------------------|--|----------------------|--|

I am the individual named above
 a personal representative because the client is a minor, incapacitated or deceased

At Family Enrichment Services, we strive to provide the most comprehensive treatment for you. Based on this, we are asking that you allow us to notify your Primary Care Physician (PCP) that you are now involved in mental health counseling and/or psychiatric services. In this way there is a continuum of care between practitioners who are committed to your care and well-being. Should you change or add providers we ask that you notify staff working with you so that we can update this information.

| | |
|---|------|
| I will authorize the exchange and release of the client's information regarding pertinent health and medical needs between Family Enrichment Services and the physician identified below. I am aware that disclosure of this information is for the purpose of coordination of care. PCP/Physician Name: _____ Address: _____ City, State, ZIP: _____ Phone: _____ FAX: _____ | |
| | |
| Signature of Parent and/or Legal Guardian/Authorized Representative (circle all that apply) | Date |
| | |
| Signature of Parent and/or Legal Guardian/Authorized Representative (circle all that apply) | Date |

This authorization is valid for: a single disclosure, up to ninety (90) days continuing disclosure for up to one year from the date of my signature as it appears above

- I understand that I do not need to sign this form in order to obtain enrollment, eligibility, treatment or payment for services.
- I understand that I have the right to refuse to sign this authorization and do not have to agree to authorize any use or disclosure.
- I understand that I can revoke this authorization at any time upon written notification to the provider named above. I further understand that revocation will not apply to information that has already been used or disclosed.
- I understand that I am authorizing the release of information from records whose confidentiality and privileged status is protected by Federal Regulations and Florida Statutes. However, the recipient of this information may not have to abide by the same federal and state privacy laws.
- I understand that I have a right to receive a copy of this authorization once I have signed it or may ask for a copy at any time by contacting the provider named above.

| | |
|---|------|
| The client currently does not have a PCP and understand that it has been recommended that I obtain one. Once obtained, I will notify the clinician assigned to my case so that the above process can be completed. | |
| | |
| Signature of Parent and/or Legal Guardian/Authorized Representative (circle all that apply) | Date |
| | |
| Signature of Parent and/or Legal Guardian/Authorized Representative (circle all that apply) | Date |

| | |
|--|------|
| I choose not to have the client's PCP or any other medical provider notified of my treatment at Family Enrichment Services. I understand that should I be prescribed medication or a significant event that warrants medical consultation arises, this issue will again be discussed with me. If necessary, a medical emergency permits use and disclosure of protected health information between health care providers for treatment (the provision, coordination, or management of health care and related services) for an individual including consultation between providers regarding a client and referral of a client. | |
| | |
| Signature of Parent and/or Legal Guardian/Authorized Representative (circle all that apply) | Date |
| | |
| Signature of Parent and/or Legal Guardian/Authorized Representative (circle all that apply) | Date |

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AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

| | |
|--------------------|----------------------|
| CLIENT NAME | DATE OF BIRTH |
|--------------------|----------------------|

I am the individual named above
 a legal guardian/personal representative because the client is a minor, incapacitated or deceased

I give permission for Family Enrichment Services to:

- Release information to:
 Obtain information from:

NAME OF PERSON / ORGANIZATION: _____

ADDRESS: _____

PHONE NUMBER: _____ **E-MAIL:** _____

The specific information to be disclosed is:

| | | |
|--|--|---|
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Assessment | <input type="checkbox"/> Communication <input type="checkbox"/> Phone <input type="checkbox"/> E-Mail <input type="checkbox"/> Written |
| <input type="checkbox"/> Medication Record | <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Narrative/Discharge Summary |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Other (specify below): |
| <input type="checkbox"/> Educational Information | <input type="checkbox"/> Substance Abuse Treatment | |

FOR THE PURPOSE OF: Coordination of care Other (specify):

I hereby authorize the disclosure of protected health information about the individual named above. I understand that my records have a privileged and confidential status. I am waiving that status for the purpose contained in this authorization.

- I understand that I do not need to sign this form in order to obtain enrollment, eligibility, treatment or payment for services.
- I understand that I have the right to refuse to sign this authorization and do not have to agree to authorize any use or disclosure.
- I understand that I can revoke this authorization at any time upon written notification to the provider named above. I further understand that revocation will not apply to information that has already been used or disclosed.
- I understand that I am authorizing the release of information from records whose confidentiality and privileged status is protected by Federal Regulations and Florida Statutes. However, the recipient of this information may not have to abide by the same federal and state privacy laws.
- I understand that I have a right to receive a copy of this authorization once I have signed it or may ask for a copy at any time by contacting the provider named above.

This authorization is valid for: a single disclosure, up to ninety (90) days continuing disclosure for up to one year from the date of my signature as it appears below

Signature of Client (If minor, Parent and/or Legal Guardian/Authorized Representative must also sign)

Date

Signature of Parent / Legal Guardian / Authorized Representative (circle all that apply)

Date

Signature of Parent / Legal Guardian / Authorized Representative (circle all that apply)

Date

Signature of Counselor / Witness

Date

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CLIENT RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of clients. A summary of your rights and responsibilities follows:

Client Rights:

- A client has the right to know about rights and responsibilities in the treatment process.
- A client has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A client has the right to fair treatment and access to treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A client has the right to a prompt and reasonable response to questions and requests.
- A client has the right to easy access to timely care.
- A client has the right to know about the insurance plan, who is providing services and who is responsible for his or her care.
- A client has the right to know about the provider's qualifications, including work history and training.
- A client has the right to request certain preferences in a provider.
- A client has the right to receive services in a language he or she can understand and know what client support services are available, such as an interpreter if he or she does not speak English.
- A client has the right to know what rules and regulations apply to his or her conduct.
- A client has the right to be given a clear explanation concerning diagnosis, planned course of treatment, alternative options, risks, and prognosis.
- A client has the right to know about treatment options regardless of cost or coverage by benefit plan.
- A client has the right to share in developing the plan of treatment.
- A client has the right to know about clinical guidelines used in providing and managing care.
- A client has the right to have the provider make decisions about care without regard to financial incentive.
- A client has the right to refuse any treatment, except as otherwise provided by law.
- A client has the right to know about advocacy, community groups and prevention services.
- A client has the right to receive services that do not jeopardize employment.
- A client has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A client has the right to give input on the Rights and Responsibilities policy.
- A client has the right to file a complaint regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency. A grievance form is available by request from your service provider or by contacting:
Linda Eaton, LMHC; Executive Director
8800 49th Street North Suite 212
Pinellas Park, FL 33782
(727) 423-7811

As a client of Family Enrichment Services, you also have a right to know about our philosophy and policy on behavior support and management. The organization promotes the use of behavior management interventions that reinforce positive behaviors, provide empathy for the child's feelings, and allow children to develop a sense of responsibility for their behavior and how it impacts their relationships with others. The organization does not permit its providers to use any restrictive behavior management practices and strongly discourages the use of these practices with our service recipients. Restrictive behavior management prac-

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tices include corporal punishment; withholding nutrition or hydration; any techniques that might inflict physical or psychological pain, or discomfort; use of demeaning, shaming, or degrading language or activities; forced physical activity as a punishment; punitive work assignments (i.e., writing sentences); use of invasive procedures for disciplinary purposes (e.g. crowding personal space, grabbing a child absent the need for restraint, etc.); chemical restraint; mechanical restraint; seclusion and manual restraint. If you would like a more complete description of each of these restrictive behavior management practices, you can request a copy of the agency's Behavior Support and Management Philosophy statement from your service provider.

Client Responsibilities:

- A client is responsible for treating the provider with dignity and respect.
- A client is responsible for providing to the provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A client is responsible for reporting unexpected changes in his or her condition or medications to the provider, including medications given to him or her by others.
- A client is responsible for asking questions about treatment and reporting to the provider whether he or she understands the treatment plan and what is expected of him or her.
- A client is responsible for following the treatment plan that is agreed upon by the client and provider.
- A client is responsible to follow the agreed upon medication plan (if applicable).
- A client is responsible for letting their provider know if the treatment plan isn't working.
- A client is responsible for keeping appointments and, when he or she is unable to do so for any reason, for calling the provider as soon as there is a need to cancel.
- A client is responsible for his or her actions if he or she refuses treatment or does not follow the provider's instructions.
- A client is responsible for following health care facility rules and regulations affecting client care and conduct.
- A client is responsible for paying any required fees and letting the provider know about any problem paying those fees.
- A client is responsible for reporting abuse or fraud.
- A client is responsible to openly report concerns about the quality of care received.

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NOTICE OF PRIVACY PRACTICES

Please review this notice carefully and ask your provider any questions you have about the information contained within it. Family Enrichment Services (herein referred to as the "Organization") is required by federal and state laws to protect your privacy and guard against unnecessary disclosure of the information contained in our records (called "*protected health information*" or *PHI*). The Privacy Rule protects your protected health information in any form or media, whether electronic, paper, or oral.

Your Protected Health Information Includes:

- Demographic information (e.g., name, address, birth date)
- Past, present or future physical or mental health or condition (e.g., symptoms, diagnosis, medications, and your prognosis)
- Past, present, or future payment for the provision of health care (e.g., claims to you and/or your insurance company)
- Appointment times and dates

YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS:

- **Treatment** is the provision, coordination, or management of health care and related services for an individual by one or more health care providers, including consultation between providers and referrals to other providers.
- **Payment** encompasses activities of a health care provider to obtain payment or be reimbursed for the provision of health care to an individual. Your PHI may be included on billing to collect payment from third parties for the services you receive.
- **Health Care Operations** are any of the following activities:
 - quality assessment and improvement activities, including case management and care coordination
 - competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation
 - conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs
 - specified insurance functions, such as underwriting, risk rating, and reinsuring risk
 - business planning, development, management, and administration
 - business management and general administrative activities of the entity, including but not limited to: de-identifying protected health information, creating a limited data set, and certain fundraising for the benefit of the covered entity.

THE FOLLOWING PROTECTED HEALTH INFORMATION HEALTH INFORMATION MAY BE USED AND DISCLOSED WITHOUT RECEIVING YOUR WRITTEN AUTHORIZATION OR PERMISSION:

Public Interest and Benefit Activities

1. Required by Law

The Organization may use and disclose protected health information without individual authorization as *required by law* (including by statute, regulation, or court orders).

2. Public Health Activities

The Organization may disclose protected health information to: public health or other government authorities authorized to receive reports of child abuse and neglect.

3. Victims of Abuse, Neglect or Domestic Violence

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In certain circumstances, the Organization may disclose protected health information to appropriate government authorities regarding victims of abuse, neglect, or domestic violence.

4. Health Oversight Activities

The Organization may disclose protected health information to health oversight agencies (as defined in the Rule) for purposes of legally authorized health oversight activities, such as audits and investigations necessary for oversight of the health care system and government benefit programs.

5. Judicial and Administrative Proceedings

The Organization may disclose protected health information in a judicial or administrative proceeding if the request for the information is through an order from a court or administrative tribunal. Such information may also be disclosed in response to a subpoena or other lawful process if certain assurances regarding notice to the individual or a protective order are provided.

6. Law Enforcement Purposes

The Organization may disclose protected health information to law enforcement officials for law enforcement purposes under the following six circumstances, and subject to specified conditions: (1) as required by law (including court orders, court-ordered warrants, subpoenas) and administrative requests; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) in response to a law enforcement official's request for information about a victim or suspected victim of a crime; (4) to alert law enforcement of a person's death, if the covered entity suspects that criminal activity caused the death; (5) when a covered entity believes that protected health information is evidence of a crime that occurred on its premises; and (6) by a covered health care provider in a medical emergency not occurring on its premises, when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime.

7. Decedents

The Organization may disclose protected health information to funeral directors as needed, and to coroners or medical examiners to identify a deceased person, determine the cause of death, and perform other functions authorized by law.

COMMUNICATIONS

8. Appointment Reminders

The Organization may contact you as a reminder that you have an appointment.

9. Treatment Alternatives

The Organization may contact you about or recommend possible treatment options or alternatives that may be of interest to you.

We may ask for informal permission to allow you the opportunity to agree or object to the sharing of your Protected Health Information. In emergency situations, we will use professional judgment to use or disclose information that is in your best interest. We will take precautions to only share the minimum necessary information in circumstances where your authorization or permission is not obtained and where allowed by the Privacy Rule.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

The Organization must obtain written authorization for any use or disclosure of protected health information that is not for treatment, payment or health care operations or otherwise permitted or required by the Privacy Rule as stated above.

Progress notes of your sessions are a separate category with their confidentiality so protected that you must give specific written permission to release them except for the following:

- Defending ourselves in legal proceedings
- Investigate or determine our compliance with the Privacy Rules
- Avert a serious and imminent threat to public health or safety
- As required by law

YOU HAVE THE FOLLOWING RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION:

1. Right to Access

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You or your representative have the right to request to inspect and copy your health information, including billing records. A request must be made in writing. Your request may be denied if I think that providing your protected health information may endanger your life or physical safety or that of another person.

2. Right to amendment

You or your representative have the right to request that corrections or additions be made to your protected health information if you believe that it is incorrect or incomplete. You or your health professional may add information to your record, but nothing will be removed. Under HIPAA regulations, your request does not require me to change anything in your health records. However, if we deny your request, we will provide you with a written explanation. If we accept your request to change or add information, we will make reasonable efforts to inform persons authorized to receive this information of the change/addition and to include the change/addition in any future sharing of your protected health information.

3. Right to a Disclosure Accounting

You or your representative have the right to request an accounting of disclosures of your health information made by the Organization for any reason other than for treatment, payment or health operations. The request for an accounting must be made in writing.

4. Right to Restriction Request

You or your representative may request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to these additional restrictions if we have substantial reasons for not honoring your request.

5. Right to Confidential Communication

You or your representative may request that we use an alternative way to communicate with you in a confidential manner or communicate with you at an alternative location about your protected health information. This request must be made in writing.

6. Right to Copy of Notice of Privacy Practices

You or your representative may receive a copy of this notice of privacy practices at any time if it is requested.

7. Right to Express Complaints

If you or your representative believe that your privacy rights have been violated, you have the right to express complaints to the Organization. We encourage you to express any concerns you may have regarding the privacy of your information. There will never be any type of retaliation against you for filing a complaint. Complaints can also be filed with the Secretary of the Department of Health and Human Services (DHHS, 330 Independent Ave SW Washington, DC 20201, toll free phone number 1-877-969-6775).

DUTIES OF THE ORGANIZATION

- We are required to abide by the terms of this notice and to provide to you or your representative this Notice of Privacy Practices. However, we reserve the right to change the privacy practices and the terms of this notice at any time, provided the changes are permitted by law or are to meet any new requirements implemented by law for the benefit of your protected health information.
- Before we make any important changes in the privacy practices, we will revise this notice and make the new notice available to you at the first available opportunity following the revisions.
- Any changes in the privacy practices and the new terms of this notice will be effective from the date of the revision forward for all protected health information in your designated record set.
- We are required to designate a Privacy Officer as a contact person for all issues regarding client privacy and your rights under the federal privacy standards.

ACCESS TO PROTECTED HEALTH INFORMATION:

If you wish to access your Protected Health Information, please provide a written request to the **Privacy Officer:**

Linda Eaton, LMHC
8800 49th Street N. Suite 12
Pinellas Park, FL 33782
Phone: (727) 423-7811
Fax: (727) 865-5178

EFFECTIVE DATE

This Notice is effective May 1, 2010