**COUPLES CLIENT INFORMATION FORM (PARTNER #1)**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **CLIENT INFORMATION (Partner 1)** |
| Last Name | First Name | Primary Phone  | OK to leave a message? |
| Email Address | OK to email?  | Birth Date  / / | Age | Gender | Ethnicity |
| Street Address City State Zip OK to receive mail?  |
| Relationship Status (please circle)Single Married Divorced Partnered Separated Widowed/Widowered | Social Security Number (optional) | Alternative Phone (Optional) | OK to leave a message? |
| Occupation | Employer | Work Phone (Optional) | OK to leave a message? |
| How were you referred? Doctor Insurance Plan Family Friend Website/other (please list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| --- |
| **IN CASE OF EMERGENCY** |
| Name of Local Friend/Relative | Relationship  | Primary Phone  | Alternative Phone |

|  |
| --- |
| **MEDICAL INFORMATION** |
| Primary Care Physician /Clinic Name  | Current Medications: |
| Have you had any recent hospitalizations? If so, for what condition? | Please list any allergies you may have: |

Please explain your primary reason(s) for deciding to begin couples therapy:

**COUPLES CLIENT INFORMATION FORM (PARTNER #2)**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| **CLIENT INFORMATION (Partner 2)** |
| Last Name | First Name | Primary Phone  | OK to leave a message? |
| Email Address | OK to email?  | Birth Date  / / | Age | Gender | Ethnicity |
| Street Address City State Zip OK to receive mail?  |
| Relationship Status (please circle) Single Married Divorced Separated Widowed/Widowered | Social Security Number (optional) | Alternative Phone (Optional) | OK to leave a message? |
| Occupation | Employer | Work Phone (Optional) | OK to leave a message? |
| How were you referred? Doctor Insurance Plan Family Friend Website/other (please list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| --- |
| **IN CASE OF EMERGENCY** |
| Name of Local Friend/Relative | Relationship  | Primary Phone  | Alternative Phone |

|  |
| --- |
| **MEDICAL INFORMATION** |
| Primary Care Physician /Clinic Name  | Current Medications: |
| Have you had any recent hospitalizations? If so, for what condition? | Please list any allergies you may have: |

Please explain your primary reason(s) for deciding to begin couples therapy:

**RELATIONSHIP INFORMATION (Complete Together)**

**Relationship Status: (check all that apply) :**

□ Married □ Separated □ Divorced □ Dating □ Cohabitating □ Living together □ Living apart

**Length of time in current relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**As you think about the main reason that brings you here, how would you rate its frequency and your overall level of concern at this point in time?**

**Concern:**

□ No concern □ Little concern □ Moderate concern □ Serious concern □ Very serious concern

**Frequency:**

 □ No occurrence □ Occurs rarely □ Occurs sometimes □ Occurs frequently □ Occurs nearly always

**What do you hope to accomplish through counseling?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What have you already done to deal with the difficulties?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What are your biggest strengths as a couple?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship.**

(extremely unhappy) 1 2 3 4 5 6 7 8 9 10 (extremely happy)

**Have you received prior couples counseling related to any of the above problems?**

□ Yes □ No

**If yes, when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**By whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Length of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Problems treated:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What was the outcome (check one)?**

□ Very successful □ Somewhat successful □ Stayed the same □ Somewhat worse □ Much worse

**Have either you or your partner struck, physically restrained, used violence against or injured the other person? If yes for either, who, how often and what happened.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has either of you threatened to separate or divorce (if married) as a result of the current relationship problems?** \_\_\_\_Yes\_\_\_\_No

**If yes, who?** \_\_\_Me \_\_\_Partner \_\_\_Both of us

 **If married, have either you or your partner consulted with a lawyer about divorce?**

**If yes, who?** \_\_\_Me \_\_\_Partner \_\_\_Both of us

**How frequently have you had sexual relations during the last month?** \_\_\_\_\_\_\_\_times

**How enjoyable is your sexual relationship?** (Circle one)

(extremely unpleasant) 1 2 3 4 5 6 7 8 9 10 (extremely pleasant)

**How satisfied are you with the frequency of your sexual relations?** (Circle one)

(extremely unsatisfied) 1 2 3 4 5 6 7 8 9 10 (extremely satisfied)

**What is your current level of stress (overall)?** (Circle one)

(no stress) 1 2 3 4 5 6 7 8 9 10 (high stress)

**What is your current level of stress (in the relationship)?** (Circle one)

(no stress) 1 2 3 4 5 6 7 8 9 10 (high stress)

**INFORMED CONSENT FOR TREATMENT**

***Privacy and Confidentiality***

Bridgeview Psychological Services (BPS) is an entity that is bound by the Code of Ethics of the profession of psychology to hold in confidence all that is disclosed during sessions, including the fact that you have met with a clinician at BPS. Psychologists within BPS (Dr. Seay, License #PSY29181 and Dr. Dashjian, License #PSY28041) may share information with each other for coordination of care. Information shared will be held confidential within BPS except in the situations outlined below.

Legal exceptions to the general rule of confidentiality require BPS to release information in the following situations:

1. When I have reason to believe that there is a clear and imminent threat to you harming yourself or another person. To protect you or others from harm, I am required by law to disclose information or take other actions to protect you or another person from physical harm. Protective actions may include contacting the police or seeking hospitalization for you.
2. When I have reason to believe that abuse of a child/minor, dependent adult, or elder adult has occurred (including the past abuse of a minor if the person who committed the abuse currently has access to minors). The state of California requires that it be reported to Child Protective Services or Adult Protective Services. Child or adult abuse includes neglect of medical needs, abandonment, sexual assault/exploitation and physical or mental injuries that result in impaired functioning. Adult abuse also includes social isolation and financial abuse.
3. When a court issues a legitimate subpoena and the court determines that confidentiality is not privileged.
4. When you are seeking third party reimbursement for mental health services, the third party payer has the right to request information for the determination of your eligibility for payment. **Your signature on this form gives me consent to disclose dates of treatment, type of treatment and the nature of the issues being treated, including a diagnosis, in accordance with HIPAA regulations.**

***Client Rights***

You have the right to ask questions about my philosophy of therapy, education/professional history, and the procedures used. You have the right to end therapy at any time; however, you should recognize that a decision to end therapy can sometimes be the result of a misinterpretation, miscommunication, or the painfulness of the material being dealt with (or not being dealt with). Should you desire to seek another therapist, I can provide you with alternatives.

***Consultation***

Consultation is a standard and ethical part of high quality mental health practice. Because I intend to provide you with the highest quality of care, I may periodically consult with other experienced licensed mental health professionals regarding your treatment. During a consultation I share limited information and avoid revealing client identity. The consultant is also bound to keep the information confidential.

***Contacting Our Office/Communications***

Bridgeview Psychological Services (BPS) can be reached at 707-816-0963. BPS does not generally conduct services on weekends or after hours. Calls to BPS are not answered or returned outside of regular business hours (M-F, 9-5 p.m.) or on holidays. BPS does not receive or respond to texts from clients due to the unsecured nature of text communications. Please be aware that email communication may ONLY be used for administrative purposes such as scheduling, payment, etc., and shall not be used for discussing personal concerns or therapy-related content. Your signature on this consent form serves as agreement to this policy.

***Emergencies***

BPS does not provide emergency therapy services or 24-hour acute care. Thus, as a clinician, I am not “on-call” for mental health emergencies. I will do my best to return calls within 48 hours during weekdays, but BPS will not be held responsible for any damages occurring as a result of unmet crisis or acute care needs. **By signing this consent form, you agree that if you are unable to reach me and are experiencing an emergency/crisis and believe you may harm yourself or someone else, you will dial 911, contact a crisis line (1-800-273-8255), or go to the nearest emergency room for evaluation.**

***Minors and Parents***

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is the policy of BPS to request oral agreement from parents to respect the confidentiality of your therapeutic disclosures. If parents agree, I will provide them only with general information about our work and progress. I will, however, notify parents if I feel there is a high risk that you will seriously harm yourself or someone else. Before giving parents information, I will first attempt to discuss the matter with you.

***Fees***

I charge a fee of $\_\_\_\_\_\_\_ per couples session. Full payment is due at the time services are rendered in the form of cash, check, debit, or credit card unless other arrangements are made. I reserve the right to change my fees, but shall provide at least 30 days notice if my fees change. A $25 fee is charged for all returned checks. If during the course of treatment you become unable to pay for sessions, I will provide referrals for low-cost therapists/services, and services with me at BPS will be discontinued.

Every month, should you request it, I will provide you with a statement that contains all the necessary information to file a claim with your insurance company for reimbursement. Whether (and to what extent) your insurance would reimburse you for sessions with me can be determined by calling your insurance representative. The client is responsible for all payments to the therapist.

***Cancellation Policy***

We understand that unforeseen circumstances may cause you to reschedule or cancel an appointment. In the event that you need to cancel an appointment, please let me know as far in advance as possible, with at least 24 hours’ notice. You will be charged the full session fee for any appointment not canceled at least 24 hours in advance. Please note that insurance carriers do not reimburse for missed appointments.

***Medication, Referral and Hospitalization***

If medication is indicated as part of your treatment, you and I will discuss various referral options. If a referral to a specialist is necessary, I will collaborate with him/her to supplement or replace our therapeutic work as needed. In some circumstances a higher level of care may be required. If this should become necessary, you and I will discuss the need for more intensive care.

***Telephone Sessions***

I do not typically charge for telephone conversations between sessions, unless they last over 10 minutes. I will prorate the normal hourly fee for longer periods or as agreed upon.

***Court-Related Fees and Risks***

BPS does not support relationships with clients seeking future legal testimonies. BPS clinicians do not do evaluations for child custody or family court cases, nor provide opinions for these. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. However, please be aware that **my testimony is not guaranteed to be solely in your favor**. Clinicians at BPS can only testify to the facts of the case and to their professional opinion.

Should a clinician at BPS be subpoenaed, or ordered by a court-of -law, to appear as a witness in an action involving you, you as the client agree to reimburse clinician for any time spent for preparation, travel, consultation, testimony, or other time in which psychologist is available for such an appearance at a set hourly rate of **$300.00 per hour**. **If the clinician is required to cancel scheduled travel plans, this fee is doubled ($600 per hour).** In addition, you are responsible for reimbursing clinician for any additional costs related to retaining an attorney (if necessary) and/or hiring consultants or specialists in order to comply with the court order or subpoena. **The estimated fees must be paid in advance**.Should costs incur beyond estimated fees, you will be billed for the additional costs, to be paid within two weeks of receipt.

By signing the consent form, you are confirming that you understand the costs and risks of seeking a BPS clinician’s legal involvement.

I have read the policies stated above, and discussed any questions or concerns. I fully understand and agree to comply with these conditions and consent for treatment by Bridgeview Psychological Services.

PRINTED NAMES OF CLIENTS:

Partner 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Partner 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT’S SIGNATURE (Partner 1): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT’S SIGNATURE (Partner 2): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### **NOTICE OF PRIVACY PRACTICES**

*THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.*

*PLEASE REVIEW THIS NOTICE CAREFULLY.*

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how BPS may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act (“HIPAA”), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *APA Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

BPS is required by law to maintain the privacy of PHI and to provide you with notice of the legal duties and privacy practices with respect to PHI. BPS is required to abide by the terms of this Notice of Privacy Practices. BPS reserves the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that BPS maintains at that time. BPS will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

**HOW BPS MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

**For Treatment**.Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation within BPS or with other licensed mental health professionals outside of BPS; however, if your PHI is shared outside of BPS, identifying information will not be revealed unless it falls under the exceptions discussed under “Without Authorization” on the following page. If you or your clinician believes it would be beneficial to share identifiable PHI for purposes of treatment/care, and the disclosure is not legally/ethically mandated, BPS will not do so without first obtaining your authorization.

**For Payment.** BPS may use and disclose PHI so that BPS can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. BPS will share this information only with your authorization. If it becomes necessary to use collection processes due to lack of payment for services, BPS will only disclose the minimum amount of PHI necessary for purposes of collection and you will be notified.

**For Health Care Operations.** BPS may use or disclose, as needed, your PHI in order to support business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, BPS may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided BPS has a written contract with the business that requires it to safeguard the privacy of your PHI.

**Required by Law.** Under the law, BPS must disclose your PHI to you upon your request. In addition, BPS must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining BPS’ compliance with the requirements of the Privacy Rule.

**Without Authorization.** Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit BPS to disclose information about you without your authorization only in a limited number of situations. The following language addresses these categories to the extent consistent with the *APA Code of Ethics* and HIPAA.

**Child Abuse or Neglect.** BPS may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

**Judicial and Administrative Proceedings.** BPS may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

**Deceased Patients.** BPS may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person’s estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

**Medical Emergencies.** BPS may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. BPS will try to notify you that the information was shared as soon as reasonably practicable after the resolution of the emergency.

**Family Involvement in Care.** BPS may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

**Health Oversight.** If required,BPS may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

**Law Enforcement.** BPS may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

**Specialized Government Functions.** BPS may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

**Public Health.** If required, BPS may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

**Public Safety.** BPS may disclose your PHI ifnecessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

**Research.**  PHI may only be disclosed after a special approval process or with your authorization.

**Education and Training.** BPS may use and disclose PHI for the purposes of training and/or education. If so, no identifying information will be shared.

**Verbal Permission.** BPS may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

**With Authorization**. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that BPS has already made a use or disclosure based upon your authorization.

**YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding PHI BPS maintains about you. To exercise any of these rights, please submit your request in writing to me or speak with me directly.

* **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a “designated record set”. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. BPS may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
* **Right to Amend.** If you feel that the PHI BPS has about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with me. I may prepare a rebuttal to your statement and will provide you with a copy. Please contact me if you have any questions.
* **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
* **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.
* **Right to Request Confidential Communication.** You have the right to request that I communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests. I may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. I will not ask you for an explanation of why you are making the request.
* **Breach Notification.** If there is a breach of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
* **Right to a Copy of this Notice.** You have the right to a copy of this notice.

##### COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with me or with the California Board of Psychology at 1625 North Market Street, Suite N-215, Sacramento, CA 95834 or online by visiting: <http://www.psychology.ca.gov/consumers/filecomplaint.shtml>. **I will not retaliate against you for filing a complaint.**

**The effective date of this Notice is November 5, 2020.**

By signing this form you are agreeing to let me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard my notice of privacy practices which explains in more detail what your rights are and how I can use and share your information.

**If you do not sign this form agreeing to my privacy practices, I cannot treat you.** In the future, BPS may change how we use and share your information, and so BPS may change their notice of privacy practices. If BPS does change it, I will give you a copy of the revised privacy practices.

If you are concerned about your PHI you have the right to ask me not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes I am not required to accept these limitations. However if I do agree I promise to do as you request. After you have signed this consent you have the right to revoke it by written request at any time. I will then stop using or sharing your PHI, but I may already have used or shared some of it at the time of your request which cannot be changed.

PRINTED NAMES OF CLIENTS:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT’S SIGNATURE (Partner 1): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT’S SIGNATURE (Partner 2): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_