Jeffrey Huttman, Ph.D., P.A.
Phone: 561-676-6785

Jeffrey Huttman, Ph.D.
Licensed Psychologist
PY7049

CHILD AND ADOLESCENT FORM

NAME: _____ DATE: _____

ADDRESS: _____

_____ ZIP CODE: _____

AGE: ____ SEX: ____ BIRTHDATE: _____ PEDIATRICIAN _____

GRADE: _____ SCHOOL NAME & LOCATION: _____

PARENT'S NAMES: _____

MOTHER'S HOME#: _____ MOTHER'S EMAIL: _____

MOTHER'S WORK#: _____ MOTHER'S MOBILE#: _____

FATHER'S HOME#: _____ FATHER'S EMAIL: _____

FATHER'S WORK#: _____ FATHER'S MOBILE#: _____

MOTHER'S SS # _____ FATHER'S SS# _____

REFERRED BY: _____

REASONS FOR THIS VISIT: _____

NAME OF PERSON FINANCIALLY RESPONSIBLE _____

HOME ADDRESS _____

CITY & STATE _____ ZIP _____

HOME PHONE _____ BUSINESS PHONE _____

SOCIAL SECURITY # _____ OCCUPATION _____

EMPLOYED BY _____

BUSINESS ADDRESS _____

_____

PRESENT STATUS:

1. PHYSICAL DATA:
   HEIGHT: _____ WEIGHT: _____ GENERAL HEALTH: _____
   APPETITE: _____ SLEEP HABITS: _____
   MEDICAL ILLNESSES/CONDITIONS: _____
   MEDICATION(S): _____

2. OTHER MEMBERS OF HOUSEHOLD (NAME, SEX, AGE, RELATIONSHIP TO CHILD):

_____

3. MARITAL STATUS OF PARENTS (PLEASE INCLUDE DATES):

_____

4. AGES AND SEXES OF SIBLINGS WHO DO NOT LIVE IN HOUSEHOLD:

_____

5. OTHER IMPORTANT PEOPLE OR RELATIVES IN CHILD'S LIFE:

_____

6. MOTHER'S EDUCATION _____ OCCUPATION: _____

   FATHER'S EDUCATION _____ OCCUPATION: _____

7. WHO TAKES CARE OF CHILD? _____

8. WHICH OF THE FOLLOWING PROBLEMS, IF ANY, DOES YOUR CHILD DISPLAY?

____SADNESS ____LOW SELF-ESTEEM ____APATHY ____IRRITABILITY ____WORRY

____AGITATION ____OBSESSIVE THINKING ____COMPULSIVE BEHAVIOR

____LOW FRUSTRATION TOLERANCE ____FEARFULNESS ____AVOIDANCE ____PANIC

____TANTRUMING ____OPPOSITIONAL/DEFIANT BEHAVIOR ____ARGUING

____DRUG/ALCOHOL USE ____SUIDICAL THOUGHTS ____HOMICIDAL THOUGHTS

____CUTTING/BURNING SELF ____UNUSUAL/ODD THINKING OR BEHAVIOR

____SOCIAL SKILLS DEFICITS ____PROBLEMS WITH PEERS ____POOR DECISION MAKING

____EATING PROBLEMS ____SLEEPING PROBLEMS ____PHYSICAL PROBLEMS

9. SCHOOL INFORMATION:
   TYPE OF CURRICULUM OR CLASS: _____

   SPECIAL CLASSES? (PLEASE DESCRIBE): _____

   HOW MANY HOURS/DAYS? IN SCHOOL _____ IN SPECIAL CLASSES:_____

10. HAS CHILD EVER FAILED A GRADE? _____ WHAT GRADE? _____

11. HOW DOES CHILD PERFORM IN SCHOOL? (BELOW AVERAGE/AVERAGE/ABOVE AVERAGE)

ACADEMICALLY: _____ SOCIALLY: _____ CONDUCT: _____

12. WHICH OF THE FOLLOWING PROBLEMS, IF ANY, DOES YOUR CHILD HAVE REGARDING SCHOOL PERFORMANCE?

____DOES NOT DO HOMEWORK ____STARTS BUT DOES NOT FINISH HOMEWORK

____FAILS TO CHECK/RUSHES THROUGH HOMEWORK ____ FORGETS ASSIGNMENTS

____PROCRASTINATES ____MESSY & DISORGANIZED ____INCOMPLETE CLASSWORK

____DISTRACTIBLE ____INTERRUPTS ____POOR ATTENTION SPAN

____TOO LONG TO COMPLETE ASSIGNMENTS ____CARELESSNESS

____DOES NOT REMAIN SEATED ____TALKS OUT INAPPROPRIATELY ____ RESTLESS/FIDGETY IN CHAIR

____NONCOMPLIANT ____ POOR HANDWRITING ____ PROBLEMS WITH WRITTEN LANGUAGE

____POOR SPELLING ____ POOR READING ____ POOR MATH

13. PEER RELATIONSHIPS:

	HOME	SCHOOL		HOME	SCHOOL
NO FRIENDS	_____	_____	MEAN/AGGRESSIVE	_____	_____
FEW FRIENDS	_____	_____	TOO SHY OR TIMID	_____	_____
MANY FRIENDS	_____	_____	BOSSY/CONTROLLING	_____	_____
LOSES FRIENDS	_____	_____	RISKY BEHAVIORS	_____	_____
TROUBLE MAKING NEW FRIENDS	_____	_____			

14. LEVEL OF CHILD'S SKILLS (BELOW AVERAGE/AVERAGE/ABOVE AVERAGE):

A. LANGAUGE (LISTENING, SPEAKING) _____

B. GROSS MOTOR (RUNNING, JUMPING, STRENGTH, BALANCE): _____

C. FINE MOTOR (WRITING, COLORING, CUTTING): _____

D. READING: _____

E. MATHEMATICS: _____

F. WRITING & SPELLING: _____

15. HOW DOES CHILD HANDLE FRUSTRATION AND ANGER? _____

16. WHAT IS CHILD'S ATTENTION SPAN & PERSISTENCE OF EFFORT LIKE? _____

17. GENERAL PICTURE OF HOW CHILD SPENDS HIS/HER DAY? _____

_____

HISTORY:

1. IS YOUR CHILD ADOPTED? _____

2. PREGNANCY & DELIVERY

   A. COMPLICATIONS: _____

   B. PLANNED/UNPLANNED: _____ PREMATURE/TERM: _____

   C. WEIGHT AT BIRTH: _____ APGAR SCORE: _____

3. HISTORY OF CHILDS MEDICAL PROBLEMS AND HOSPITALIZATIONS. (INDICATE TYPE OF PROBLEM AND AGE AND ANY CHANGES IN THE CHILD THEREAFTER):

_____

4. ACCIDENTS, POISONINGS, EMOTIONAL OR PHYSICAL TRAUMAS (INDICATE TYPE OF PROBLEM AND AGE):

_____

5. ANY EVIDENCE OF HEARING OR VISION PROBLEMS? WHEN WAS CHILD TESTED FOR THESE?

_____

6. PLEASE INDICATE THE SEQUENCE OF CHILD-CARE ARRANGEMENTS SINCE BIRTH:

_____

7. DISRUPTIONS IN FAMILY OR CHANGES IN MEMBERS OR HOUSEHOLD. INDICATE NATURE OF CHANGE AND AGE OF CHILD AT THE TIME:

_____

8. DEATHS OR SEPARATIONS FROM IMPORTANT PEOPLE. INDICATE NATURE OF RELATIONSHIP, TYPE OF PROBLEM AND AGE OF CHILD:

_____

9. HISTORY OF CHILDS EDUCATION (AGE STARTED SCHOOL AND SCHOOLS ATTENDED, DATES, ETC.)

_____

DEVELOPMENTAL INFORMATION:

1. INDICATE BOTTLE OR BREAST FED & AGE OF WEANING: _____

2. AGE CRAWLED: _____ 3. WALKED ALONE: _____

4. AGE SPOKE: 1 WORD _____ STRUNG 3 OR MORE WORDS TOGETHER _____

5. AGE POTTY TRAINED: DAY _____ NIGHT _____

   HOW LONG DID TRAINING TAKE ? _____

6. AGE BLADDER TRAINED: DAY _____ NIGHT _____

   HOW LONG DID TRAINING TAKE? _____

7. TEMPERAMENT (INFANCY, TODDLER, PRE-SCHOOL) CHECK ANY THAT APPLY:

____ SHY OR TIMID ____FEARFUL ____ IMPULSIVE ___ ROCKING ____ STUBBORN

____ CAUTIOUS ____ POOR SLEEP ____ HEADBANGING ___ AFFECTIONATE

____ UNDERACTIVE ____ CURIOUS ____ INTO EVERYTHING ____ TEMPER OUTBURSTS

____ TORE UP TOYS MORE THAN NORMAL ____ WANTED TO BE LEFT ALONE

____ EASY TO MANAGE ____ SLOW TO WARM UP ____DAREDEVIL OR HIGH RISK BEHAVIOR

____ MORE INTERESTED IN THINGS THAN IN PEOPLE ____ PROBLEMS WITH TRANSITIONS

____ HAPPY ____ AGGRESSIVE ____ POOR EATING ____ COLICKY

____ STARRING/BLANK SPELLS _____ FALLING SPELLS

8. ANYTHING ELSE YOU THINK THE DOCTOR SHOULD KNOW?

_____

THE FUTURE:

1. WHAT DO YOU EXPECT FROM YOUR CHILD IN THE FUTURE?

_____

2. WHAT KIND OF HELP OR SCHOOLING WOULD YOU LIKE HIM/HER TO RECEIVE?

_____

3. WHAT KIND OF HELP DO YOU NEED OR WOULD YOU LIKE TO RECEIVE TO ASSIST YOU IN DEALING WITH YOUR CHILD?

_____

FAMILY INFORMATION:

	HISTORY OF MENTAL ILLNESS DEPRESSION OR ANXIETY	ALCOHOL OR DRUG ABUSE	SCHOOL PROBLEMS	EMPLOYMENT PROBLEMS	CHRONIC OR SEVERE HEALTH PROBLEMS
MOTHER					
FATHER					
BROTHER					
BROTHER					
BROTHER					
SISTER					
SISTER					
SISTER					
MATERNAL GRANDMOTHER					
MATERNAL GRANDFATHER					
PATERNAL GRANDMOTHER					
PATERNAL GRANDFATHER					
STEP-MOTHER					
STEP-FATHER					
OTHER					
OTHER					

Jeffrey Huttman, Ph.D., P.A.

Licensed Psychologist

OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

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

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

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with me. At the end of the evaluation, I will notify you if I believe that I am not the right therapist for you and, if so, I will give you referrals to other practitioners whom I believe are better suited to help you.

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 1 to 2 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If we agree to begin psychotherapy, I will usually schedule one [45-minute] session (one appointment hour of [45] minutes duration) per week, at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to

pay for it unless you provide 24 hours advance notice of cancellation. If it is possible, I will try to find another time to reschedule the appointment.

PROFESSIONAL FEES

My hourly fee is $180 for minors and $200 for adults. If we meet more than the usual time, I will charge accordingly. In addition to weekly appointments, I charge this same hourly rate for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, psychological assessment/testing if and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. I charge $350 per hour for professional services I am asked or required to perform in relation to your legal matter. I also charge a copying fee of $1.00 per page for records requests.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when such services are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

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

INSURANCE REIMBURSEMENT

I do not participate directly with any insurance plans, and therefore am considered an out-of-network provider for most insurance. However, many patients with insurance coverage are able to get some reimbursement for clinical services if they are interested in doing so. For patients interested in submitting to insurance, I can provide a copy of paid invoice statements upon request so patients can submit themselves. Please consult with your insurance company if you have questions regarding your insurance benefits and reimbursement rates.

CONTACTING ME

I am often not immediately available by telephone. Though I am usually in my office between 9 AM and 5 PM, I probably will not answer the phone when I am with a patient. When I am unavailable you may leave a detailed voice message on my confidential phone that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays, and will return all calls within 24-hours. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach

me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

CONFIDENTIALITY [for adult patients]

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child [elderly person or disabled person] is being abused or has been abused, I must [may be required to] make a report to the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice I am unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and I am not an attorney

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

PATIENT SIGNATURE _____ DATE _____

MINORS

Parent Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

Individual Parent/Guardian Communications with Me

In the course of my treatment of your child, I may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, my patient is your child – not the parents/guardians nor any siblings or other family members of the child.
If I meet with you or other family members in the course of your child's treatment, I will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your or your child's permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.
- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm [and the police].

- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
- Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am required by law to report the alleged abuse to the appropriate state child-protective agency.
- I am ordered by a court to disclose information.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

> ***Example***: If your child tells me that he/she has tried alcohol at a few parties, I would keep this information confidential. If you child tells me that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, I would not keep this information confidential from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I would not keep that information confidential.
>
> ***Example***: If your child tells me that he/she is having voluntary, protected sex with a peer, I would keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will not keep this information confidential.

You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that he or she were doing _____, would you tell the parents?"

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor's Treatment Records to Parents

Although the laws of Florida may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me, and you agree not to request access to your child's written treatment records.

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $350 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Child/Adolescent Patient:

By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask me at any time.

Minor's Signature* _____ Date_____

Parent/Guardian of Minor Patient:

Please initial after each line and sign below, indicating your agreement to respect your child's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. _____ _____

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment. _____ _____

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above. _____ _____

Parent/Guardian Signature _____ Date_____

Parent/Guardian Signature _____ Date_____

* For very young children, the child's signature is not necessary

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PY7049

NOTICE TO ALL PATIENTS:

Effective April 14, 2003, a new Federal Law requires that each person who consults a health care provider in the United States must receive a copy of the privacy policies and practices notice form of the new Health Insurance Portability and Accessibility Act (HIPAA).

Attached is a copy for you to read and keep.

By signing below, you are simply attesting to the fact that I have given you the required notice.

My signature acknowledges that I have received a copy of the Notice of Privacy Practices for Protected Health Information.

Signature_____

Date_____

04/03

Reflections in the Park
2200 Corporate Blvd., N.W. Suite 110 — Boca Raton, FL 33431 — (561) 994-4565 — Fax (561) 994-3552

10/06/2013

FLORIDA NOTICE FORM

Our Policies and Practices to Protect the Privacy of Your Health Info

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY[1].

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

I may *use* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. Here are some definitions:

- *PHI* refers to information that could identify you.
- *Treatment* refers to health care services. An example would be when I consult with another provider, such as your family doctor or another psychologist.
- *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples include quality assessment, improvement, audits, administrative services, case management and care coordination.
- *Use* applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *Disclosure* applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses Requiring your approval and signature

I may use PHI for purposes outside of treatment, payment, and health care operations when you approve. An "*authorization*" is written permission above and beyond the general consent that permits specific disclosures. When I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing information. I will also need to obtain an authorization before releasing your psychotherapy notes. "*Psychotherapy notes*" are notes I have made about our conversation during a counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

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[1] For the sake of clarity, the phrase "use and disclose" has been shortened to "use"

III. Uses with Neither Consent nor Authorization

I may use PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to the Florida Department of Child and Family Services.

- **Adult and Domestic Abuse:** If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

- **Health Oversight:** If a complaint is filed against me with the Florida Department of Health on behalf of the Board of Psychology, the Department has the authority to subpoena confidential mental health information from me relevant to that complaint.

- **Legal Proceedings:** If you are involved in a legal proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

- **Worker's Compensation:** If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

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

IV. Your Rights and my Duties

Your Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses of PHI about you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

My Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you in person or by phone.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other questions about your privacy rights, you may contact me at 561-676-6785.

If you believe your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to me at 2200 Corporate Blvd., N.W. Suite 110. Boca Raton, FL 33431

You may also send a written complaint to the secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

You have specific rights under the HIPPA Privacy Rule. I will not retaliate against you for exercising your rights to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on 04/14/2013.

I will limit the uses or disclosures that I will make as follows:

_____

_____

I reserve the right to change the terms of this notice and to make the new provisions effective for all PHI that I maintain. I will provide you with a revised notice by phone por in person.

Electronic Communication Policy

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with me.

Email Communications

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

Text Messaging

Because text messaging is a very unsecure and impersonal mode of communication, I do not text message to nor do I respond to text messages from anyone in treatment with me. So, please do not text message me unless we have made other arrangements.

Social Media

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

Websites

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

Web Searches

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional with whom you are working, please share it with me so we can discuss it and its potential impact on your therapy. Please do not rate my work with you while we are in treatment together on any of these websites. This is because it has a significant potential to damage our ability to work together.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____