Behavioral Health Associates, P.C.
3709-22nd Place, Suite C
Lubbock, Texas 79410

Behavioral Health Associates, P.C.
Brian D. Carr, Ph.D.
PATIENT INFORMATION

Personal Information - Please Print

Name______________________________________ Sex______ Age______

Date of Birth_______________

Address____

City/State/Zip____

Phone: Home____________ Work___________ Check Here if you do not have a phone__

E-mail____

Are you employed? __Yes _No Do you attend school? __Yes _No

Name/Address/Phone # of Nearest Relative Not Living With You

____

Marital Status______ Spouse's Name_____________________

Who Referred You to This Office?____

Do you have a Primary Care Physician? __Yes __No
If so may we contact them if needed? __Yes __No If you grant permission to contact your PCP please provider their name and telephone number below:

Insurance Information - Primary Carrier Only

Insurance
Company____

Group Number or Name________________________ Policy #___________________

Name of Insured____

Insured's D.O.B.__________________ Insured's SS#______________________________

Billing Information

Responsible Party (Last, First & M.I.) ____

Address ____

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Phone: Home___________________ Work___________________

Birthdate________________ Your Relationship to Responsible Party______________

The HIPAA regulations provide for the restriction of your personal health information (PHI) in terms of release to other parties. You can set these guidelines for how you should be contacted and with whom your PHI can be shared.

I prefer to be contacted using the following methods (check all that apply)

__Home Telephone:________________
- __Acceptable to leave detailed message
- __Leave message with call-back number only
- __Acceptable to fax to this number

__Written Communication
- __Acceptable to mail to home
- __Acceptable to mail to work

__Work Telephone:_________________
- __Other____________________
- __Acceptable to leave detailed message
- __Leave message with call-back number only

______________________________ ______________________________
Patient's Signature Date

Release of Information

Your privacy is important to us and we want to protect your personal health information. Please check below who we may release information to. You have the right to revoke this permission at anytime by communicating your desire to us either written or oral.

___my physician, please identify___________________________
___my spouse
___my family, please identify______________________________
___my attorney, please identify____________________________
___my children, please identify____________________________

Advanced Health Directives
Please check the appropriate statements

1. ___I have ___I have not executed an Advance Directive for Health Care
2. ___I have ___I have not executed an Advance Directive for Mental Health Care
3. ___I have ___I have not executed an Out-of-Hospital DNR

Do you wish to receive information about any of these documents?
___Yes ___No

A copy of my ___Advance Directive __Advance Directive for Mental Health Care

___Out-of-Hospital DNR is in the possession of:

Name:_________________ Telephone:___________________________

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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 IT CAREFULLY.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices please contact:

Brian D. Carr, Ph.D.
3709-22nd Place
Lubbock, Texas 79410
(806) 795-3911

Effective Date of This Notice: April 14th 2003

I. How the practice may Use or Disclose Your Health Information

This practice collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of the practice, but the information in the medical record belongs to you. The practice protects the privacy of your health information. The law permits the practice to use or disclose your health information for the following purposes:

1. Treatment: We will use the health care information we learn about you to provide you with health care services.

   (i) The following people in our office will have access to your information:

   a. Clinical staff – psychologists
   b. Reception staff
   c. Medical records personnel

   (ii) We have established standards and procedures that limit various staff members' access to your health information according to their primary job functions. These standards and procedures may change from time to time. All of our staff is required to sign a confidentiality statement.

   (iii) We will share your health care information with other health care providers involved in your care.

   1) When we provide care to you when you are hospitalized, we will share your health care information with personnel of that hospital. That hospital will have a privacy and confidentiality policy like this one. If you have questions about their policy, you should ask them.
   2) When we refer you to a specialist, we will share your health care information with them. We will send this information whether you actually see the specialist (for example, a surgeon) or whether you do not (for example, if we send a specimen to a laboratory for analysis). That specialist will have a privacy and confidentiality policy like this one. If you have questions about their policy, you should ask them.
   3) When we submit laboratory specimen to reference laboratories.

   (iv) We will share your health care information with other people associated with your care at our office. These include:

   1) Family members you involve in your care
   2) Friends you choose to include in your care
   3) Other caregivers you choose to involve in your care
   4) Other parties actively involved in your care

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2. Payment: we will use and disclose your health care information to seek reimbursement for services we render you and members of your household. In this process, other parties may have access to the information you give us.
(i) In this context, these parties include:
    1) Our business office staff
    2) The insurance organizations involved in your care
    3) An organization that may mail our statements to you
    4) If one is required, the collection agency we use to collect unpaid balances.
    5) Other firms that become involved in the process of processing or reviewing payment activities.

3. Regular Health Care Operations: we will use and disclose your health information to keep our practice operable.
(i) Examples of this kind of personnel include, but are not limited to, the following:
    1) Our medical records staff
    2) Outside health or management reviewers
    3) Individuals performing similar activities
(ii) Governmental Oversight Activities – if we receive proper instruction from a party with applicable jurisdiction, we will use and disclose your health information to support activities associated with audits, investigations, license reviews, applications for privileges, and in compliance with governmental programs and laws.
(iii) As required by law – we will use and disclose your health care information as required by a court or administrative order, subpoena, discovery request, or other lawful process. We will use and disclose your information when requested by national security, intelligence, and other State and Federal officials, and/or if you are an inmate or otherwise under the custody of law enforcement.
(iv) For appointment reminders – we will use and disclose your health information to remind you of appointments you have made in our office or elsewhere.
(v) Treatment alternatives – we will use and disclose your health information to seek out treatment alternatives for you of which we become aware in the professional or popular literature.
(vi) Research – we will use and disclose your health information to participate in research programs that have proper governmental approval. If your information is to be presented in a format that would allow individual identification, we will seek your written authorization before disclosing it.
(vii) Upon military command – if you currently serve in the military or are a veteran, we will disclose your information upon proper military command.
(viii) To prevent a serious threat to health or safety – if a licensed member of our staff determines, in his or her best professional judgment, that there is a serious threat to the health or safety of you or some other individual, we will disclose your health information to the proper authorities.
(ix) To discharge public health responsibilities – We will disclose your health care information to report deaths, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, and to prevent and control disease, injury, and disability.

4. Information provided to you: You have the right to:
Inspect and copy your health care information, or that of an individual for whom you are a legal guardian.
(i) If you wish to examine your health care information, you will need to complete and submit the appropriate form available from our office. Additional copies are available separately.
(ii) After we receive the form, we will determine whether to permit you to examine your health care information. In some cases, we may refuse to permit you to do so. Examples of reasons why we would refuse include, but are not limited to, the following: A determination that doing so might harm you, or might harm another person.

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(iii) Unless we decide to refuse permission to review your health care information, we will make an appointment for you to review the information. You will do so in a private room, with a member of our staff available to assist you in finding information. We may charge a fee for this service.
(iv) While reviewing the information, you will have the right to a copy of parts or all of your health care information. We may charge a fee for this service.

You have the right to amend health care information, if you feel it is inaccurate or incomplete.

(i) To request an amendment to your health care information, please request and complete the amendment form available in our office. Additional copies are available separately.
(ii) We will review your request to amend your record. We may decide to deny the amendment. Examples of reasons why we would refuse include, but are not limited to, the following: If we feel it is false or misleading, or could harm you or some other person.
(iii) If we accept your amendment, we will attach it as a permanent document in your health care record. If you make reference, individually and specifically, to specific documents in your health care record, we will append a note to each such document referring a future reader to your amendment. You need to describe each document individually. If you do not identify any particular documents or simply state “all” (or some similar language), then we will add your amendment as a separate document into the chart, but not append notes to any other documents.

You have the right to receive a list of non-routine disclosures we have made of your health care information.

(i) When we refer you to a specialist as described above, we make a routine disclosure of your health care information that we think will be necessary and appropriate for treatment, payment, and health care operations. We do not keep record of these routine disclosures.
(ii) You can request a list of non-routine disclosures of your health care information we have made. We will provide you a list of these disclosures during the subsequent six years, beginning with April 14, 2003. To request a list of these disclosures of your health care information, complete and submit the appropriate form available in our office. Additional copies are available separately.

You have the right to request a limit to the health care information we disclose about you.

(i) If you wish to do so, write a letter describing your concerns and wishes to your physician or to our Privacy Officer.
(ii) We are not obligated to acquiesce to your request. However, if we do agree, we will comply with your requests in all subsequent decisions to use and disclose your health care information.

You have the right to request confidential communications.

(i) In general, we will not disclose your health care information except as described above. If, however, you wish us to restrict further the parties who will have access to your information, please request the appropriate form available from our office.
(ii) We are not obligated to acquiesce to your request. However, if we do agree, we will comply with your requests in all subsequent decisions to use and disclose your health care information.

5. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

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7. Required by law. As required by law, we may use and disclose your health information.

8. Public health. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

9. Health oversight activities. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.

10. Judicial and administrative proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.

11. Law enforcement. We may disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

12. Deceased person information. We may disclose your health information to coroners, medical examiners and funeral directors.

13. Organ donation.We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

14. Research. We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board or the privacy board.

15. Public safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized government functions. We may disclose your health information for military, national security, prisoner and government benefits (only for health plans) purposes.

17. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws.

18. Marketing. We may contact you to provide appointment reminders or to give you information about other treatments or health-related benefits and services that may be of interest to you.

19. Change of Ownership. In the event that the practice is sold or merged with another organization, your health information/record will become the property of the new owner.

II. When the practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, the practice will not use or disclose your health information without your written authorization. If you do authorize the practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

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III. Changes to this Notice of Privacy Practices

The practice reserves the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, the practice is required by law to comply with this Notice.

IV. Complaints

You have the right to file a complaint with us about our adherence to these policies.
(i) Your complaint should be directed to our Privacy Officer.
(ii) You can either write a letter addressed to the Privacy Officer, or complete and submit the appropriate form available from our office. Additional copies are available separately.
You have the right to file a complaint with the Secretary of Health and Human Services.
(i) You should write a letter describing your concerns.
(ii) The letter should be addressed as follows:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Telephone: 202-619-0257
Toll Free: 1-877-696-6775

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Consent for the Use or Disclosure of Protected Health Information

Brian D. Carr, Ph.D.
3709-22nd Place - Lubbock, TX 79410

As required by the Health Insurance Portability and Accountability Act of 1996 this practice may not use your personal health information for the purposes of treatment, payment or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Information Practices. You have the right to review the Notice of Information Practices prior to signing this consent form. You may request restrictions on the uses and disclosures described in the notice of information practices by describing the requested restrictions in the "restriction request" section of this form. You may revoke this consent at any time by signing and dating the revocation section on your copy of the form and returning it to this office.

<u>CONSENT SECTION</u>

I, ____________________ (print name) hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. My signature below indicates that I have been given an opportunity to read the Notice of Information Practices and to have any questions answered before signing.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request section of this form. I further understand that the practice is not required to accept my restriction request.

I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form and returning it to the practice. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

________________________________ ________________________________
Signature Date

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RESTRICTION REQUEST SECTION

I hereby request the following restrictions on the uses and disclosures of my health information (please describe the requested restrictions in detail):

___

___

___

___

___

Signature   Date

REVIEWER SECTION

The terms of this request are / are not (circle one) acceptable.

Signature   Date

Brian Carr, Ph.D.   Privacy/Security Committee Members
Print Name   Title

Reviewer's comments:

___

___

___

___

___

REVOCATION SECTION

I hereby revoke this consent.

Signature   Date

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