Dianne S. Johnson, LCSW
601 Bombay Lane, Roswell, GA 30076
Office: 404-576-8454 • Facsimile: 770-754-4676
www.diannesjtherapy.com

Dear Patient,

The attached is a set of your clinical intake documents and several documents relevant to the Healthcare Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA mandates several of the following documents by law.

Although this package appears lengthy, please take the time to fill it out accurately and understand its contents, particularly my office policies. Doing so will facilitate our ability to work in therapy/counseling together.

In order to make efficient use of available appointment times and to insure that those patients who are on the waiting list for appointments have every opportunity to obtain an appointment I have a strict 24 business hour cancellation policy. It is your responsibility to cover the costs associated missed appointments.

Please fax (770-754-4674) or email these documents to me prior to your appointment or bring the completed documents to our first appointment.

Thank you so much for your understanding and cooperation.

For directions to the office go to www.diannesjtherapy.com.

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PATIENT REGISTRATION FORM

First Name: _______________________________ Last Name: ________________________________ Middle Name: ________________________

Address: ____ City: ___________________ St: _______ Zip: ______________

Home Telephone #: _______________________________________ Alternate Telephone #: ____

Date of Birth: _______/_______/__________ Social Security No.: ________-______-__________ Sex: _____________Age: __________________

Responsible Party: ____ Relationship: ____________________________________

Occupation: ____ Work Telephone: __________________________________

Employer and Address: ____

Patient's Spouse or Parent (If Minor): ____ Telephone #: _____________________________

Emergency Contact: ___________________________________ Relationship: _________________Telephone #: ______________________________

May we contact you via:

☐ How were you referred to me?
____

Home Phone _________________________ Yes No
Work Phone _______________________ Yes No
Cell Phone ________________________ Yes No
E-mail Address _____________________ Yes No

I authorize the release of medical information necessary to process any of my insurance claims and I authorize payment of medical benefits directly to Dianne Stanford Johnson, LLC for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. I am aware that if I will be charged the insurance allowable rate, or standard fee if private pay, for any missed appointments which are not rescheduled or cancelled within 24 hours of the scheduled appointment time. I authorize Dianne S. Johnson, LCSW to file a claim for these services (and to refile as necessary to collect) with the patient's insurance(s) and bill the patient for any amounts for which they are responsible. I further authorize Dianne S. Johnson, LCSW to sign said claim(s) or any refiled claims on my behalf. The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or patient that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fee and collection expenses.

Name: ____Signature: ___________________________________ Date: _____________

INSURANCE INFORMATION

Company Name: ____Telephone #: _________________________________

Member ID Number: ____________________________________ Group No.: ____

Policy Holder's Social Securtiy No. (if different from Patient): _______-_____-_______ Policy Holder Date of Birth: ___________________

Policy Holder (if different from Patient): ____ Relationship: ___________________________

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Counseling Concerns

Why are you seeking help now?

____

____

____

What would you like to see happen as a result of counseling or psychotherapy?

____

____

____

Medical & Psychological History

Primary Care MD____Phone Number:______________________

Address____City__________________State_____ZIP______________

Date of last Physical Exam__________________

Have you discussed the reason(s) for your visit today with your doctor? Yes No

Psychiatrist____Phone Number_________________________

Address____City________________State_________ZIP__________

Referred By______________________________

Marital Status:
- ❑ Single
- ❑ Married How long?__________________
- ❑ Divorced How long?__________________
- ❑ Widow/Widower How long?__________________
- ❑ Domestic Partnership How long?__________________
  Cohabitation

Living Situation: Own Rent
- ❑ House
- ❑ Condominium
- ❑ Apartment
- ❑ Other________________

Have you served in the Armed Forces (if yes, please explain)____

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Please describe the reason for your visit:____

____

Have you experienced similar or identical problems in the past? Yes No

Please explain____

____

Have you ever been treated or hospitalized for psychiatric, emotional, behavioral, or substance abuse problems? Yes No

Please list all circumstances, dates, and locations, and names of clinicians:_______________________________

____

Please list all medications (including dosages) that you are currently taking and the name of the prescribing doctor:

____

____

Do you have any medication or other allergies? Yes No

Please List____

Do you have a history of head injuries or seizures? Yes No

Please Explain____

Do you have pain management issues? Yes No

Please Explain____

Do you have a history of developmental and/or educational difficulties? Yes No

Please Explain____

Do you have any medical issues? Yes No

Please Explain____

Have you ever had a problem with or been treated for drug or alcohol abuse or other addiction/compulsive behavior (eating disorder, gambling, sex, Internet, shoplifting/theft, etc.) or participated in any kind of recovery program?
Yes No

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Circle any of the following you have used in the past 30 days and give an estimate of how much you typically use: tobacco, alcohol, marijuana, tranquilizers, sleeping pills, pain killers, heroin, cocaine/crack, amphetamines/speed, Benzodiazepines, Methadone, LSD, Ecstasy, inhalants.
Please list any of these or other substances that you have used in the past________________________________

____

____

Have you ever experienced withdrawal symptoms? Yes No Blackouts? Yes No

Have you ever had a DUI? Yes No

Circle your current employment status: full time part time unemployed

homemaker student retired disabled

Are you having difficulties at work or concerns about your job? Yes No

Please Explain____

Does anyone in your family have/had psychiatric, emotional, behavioral, or addiction problems? Yes No

Please Explain____

Do you have difficulties or concerns about how you get along with other people? Yes No

Please Explain____

Do you have spiritual or religious concerns? Yes No

Please describe your religious upbringing and current beliefs ___________________________

____

Do you have any sexual orientation issues or concerns? Yes No

Please Explain____

Do you have any legal problems? Yes No

Please Explain____
Have you ever experienced abuse? Yes No

- ❑ physical
- ❑ emotional
- ❑ sexual

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Please list all of your children, including their ages:____

____

Please list everyone who currently lives with you and your relationship to them: ___________________________

____

Please list all the adults (caregivers) and children (siblings or others) with whom you lived when you were a child (birth to 18 years old) and note their relationship to you (for example: biological mother; stepfather; sister - older by 16 months; male cousin – younger by 3 years; etc.). Please indicate if any of these people are deceased.

____

____

Are you, or is anyone in your family adopted (if yes, please elaborate)____________________________________

____

Please tell me a little bit about any significant losses you have experienced throughout your life, if any (deaths, divorces, lost friendships, broken relationships or anything that caused you emotional pain). Continue on back if needed.

____

____

Please circle your level of education: Completed______Grade / HS Diploma / GED / Some College / Technical School / College Degree / Graduate Degree(s)

Area of interest/expertise/type of degree____

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Please explain any recent changes have you experienced in the following (continue on back if needed):

- ❑ Mood____
- ❑ Sleep____
- ❑ Concentration____
- ❑ Energy____
- ❑ Interest in things that you normally enjoy____
- ❑ Appetite____
- ❑ Libido____
- ❑ Feelings of guilt____
- ❑ Thoughts of hurting yourself/suicide____
    - If you have these thoughts now or have ever had them in the past, please indicate dates and circumstances_ ____
    - Has anyone close to you ever committed suicide or talked about hurting him or herself? ______________ ____
- ❑ Thoughts of hurting someone else____

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Please check any that apply:

Thoughts/Feelings/Mood

- ☐ Anger/frustration/hostility
- ☐ Inattention
- ☐ Depression
- ☐ Excessive worry
- ☐ Fear
- ☐ Grieving (death, divorce, etc.)
- ☐ Hallucinations
- ☐ Intrusive thoughts
- ☐ Judgment problems
- ☐ Memory difficulties
- ☐ Negative thoughts
- ☐ Obsessive thoughts
- ☐ Panic attacks
- ☐ Sadness
- ☐ Self-esteem
- ☐ Shyness
- ☐ Stress
- ☐ Sudden mood changes
- ☐ Suicidal or Homicidal thoughts

Other Concerns

____

____

____

Behavior

- ☐ Abuse
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Argumentative
- ☐ Compulsive behavior/rituals
- ☐ Controlling
- ☐ Decreased/lack of sexual interest
- ☐ Destruction of property
- ☐ Eating problems
- ☐ Financial problems, debt
- ☐ Hyperactivity
- ☐ Internet problems
- ☐ Isolation
- ☐ Legal problems
- ☐ Codependency
- ☐ Lying
- ☐ Unable to relax
- ☐ Eating Disorder
- ☐ Self destruction/sabotaging
- ☐ Self-neglect
- ☐ Sexual dysfunction
- ☐ Stealing
- ☐ Weight, gain/loss
- ☐ Withdrawal from others
- ☐ Loss of interest in former pleasures
- ☐ Sleep difficulty

Family & Relationships

- ☐ Affair
- ☐ Childhood (your childhood)
- ☐ Divorce/Separation
- ☐ Interpersonal Conflicts
- ☐ Parenting
- ☐ Relationship
- ☐ Problems/Differences

Addiction

- ☐ Abuse of alcohol
- ☐ Abuse of drugs
- ☐ Dependency
- ☐ Drug use— OTC, prescription, street
- ☐ Gambling
- ☐ Pornography
- ☐ Preoccupation with

Work & School

- ☐ Absenteeism
- ☐ Career concerns
- ☐ Difficulty w/coworkers
- ☐ Difficulty w/supervisor
- ☐ Performance
- ☐ Tardiness
- ☐ Procrastination
- ☐ School problems

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Therapist-Patient Services Agreement
(Office Policies and Consent to Treatment)

Welcome to My Practice
This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purposes of treatment, payment, and health care operations (TPO). HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for TPO. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information so I ask that you sign both the Agreement and the Notice. Although these documents are long and sometimes complex, it is important that you read them carefully. We can discuss any questions you have about the documents at any time. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

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

Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been show to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in personal distress. Of course, there are no guarantees about 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 specific treatment plans to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. 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 refer you to another therapist who may be better suited to your needs.

Meetings/Sessions
The paperwork you have received helps me to understand your medical situation and make a diagnosis, if appropriate. Insurance will not pay for visits that are not deemed a "medical necessity". Following our first visit, I normally conduct a less formal evaluation that will last from 2 to 4 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. Each individual session will last for 45 to 55 minutes depending on your insurance allowance. The final five minutes will be to schedule our next session. I strive to be punctual and I expect you to respect that your session ends after 50 minutes. If a patient has a consistently difficult time leaving on time, such behavior will necessarily and appropriately become a subject in treatment. If you are not able to keep your scheduled appointment, your will be expected to pay a $75.00 missed appointment fee unless you provide at least 24 hours advance notice of cancellation (48 hour notice is required if the cancellation is for a Monday appointment). Please note that insurance will not reimburse for cancelled or missed sessions. If you have a "standing" appointment and cancel frequently, even within these guidelines, you may be required to relinquish your standing appointment and schedule on an individual basis.

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Professional Fees
Unless you use insurance (BC/BS, Cigna, United Healthcare, or Medicare), my per-session fee is $125.00. In addition to appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, and the time spent performing any other service you may request of me that is not specifically covered by insurance. I am not trained in forensic evaluation or testimony and I am not an expert witness; therefore I do not participate in legal proceeds on behalf of my patients. If you become involved in legal proceedings and I am required to be present or to provide my time, copies, or other services you will be expected to pay for all of my professional time, including preparation time and all costs incurred, even if another party calls me. This payment must be paid in advance of my participation. My fee for participation at any legal proceeding is $250.00 per hour with an eight-hour minimum ($2000.00). Travel time will be billed in addition to actual court time.

Standing Appointments
Many of my patients prefer to establish a “standing” appointment, which I encourage. Standing appointments are not meant to be a “holding” mechanism to ensure that you have a session reserved for you “just in case”. Standing appointments are a contract to attend every session reserved for you, within reason. If you establish a standing appointment but cancel frequently, even with appropriate 24-hour notice, you will be required to relinquish your standing appointment and schedule your appointments one at a time.

Contacting Me

Voicemail:
Due to my work schedule, I am not immediately available by telephone or in person. My calls will go to confidential voicemail because I am with patients most, if not all of the day. I will make every effort to return your call on the same day you made it, or at least within 24 business hours, depending on when you leave the message and what my schedule entails. Exceptions to this standard include weekends, holidays, and personal time away from my practice. If your have any sort of emergency, please call 911 or go to the nearest emergency room. If I will be unavailable for an extended period of time, I will provide you with the name of a colleague to contact, if absolutely necessary.

Email:
I do not conduct therapy via email. It is important to be aware that e-mail communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that remote servers have unlimited and direct access to all e-mails that go through them. Please notify me if you decide to avoid or limit, in any way, the use of e-mail. I encourage you to consider the limits to confidentiality inherent in the email process. I endorse the use of email to arrange or modify appointments as long as you understand and accept the limits to confidentiality that it presents. .

You are welcome to use my email to communicate non-urgent information with me. Do not ever use my email to communicate urgent and/or life-threating information. Email is NOT to be used in the case of an emergency. If you are experiencing an urgent and/or life-threatening emergency you must immediately call 911 or go to you local hospital emergency room.

Social Media Policies:
I do not accept “friend” or contact requests from current or former patients on any social/professional networking site (Facebook, LinkedIn, etc.). These sorts of connections may compromise your confidentiality and our respective privacy. These connections also may blur the boundaries of our therapeutic relationship and potentially have unforeseen negative consequences for you as my patient.

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Termination of Therapy
The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or I determine you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, new treatment plan or terminating your therapy. It is best to discuss this in a planned termination session. If you do not call or show for two consecutive scheduled sessions or I do not hear from you within 30 days, this will act as an indicator you are choosing to terminate treatment.

Limits to Confidentiality
The law protects the privacy of all communications between a patient and a therapist. In most situations, I can only release information about your treatment if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that only require that you provide written, advanced consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record and Psychotherapy Notes (as defined in my "Georgia HIPAA Privacy Notice", attached).
- You should be aware that I practice with other mental health professionals associated with North Fulton Treatment Center and that the group employs administrative staff. In most cases, I need to share at least some PHI with these individuals for both clinical and administrative purposes, such as scheduling, billing, and coordination of care. All of the individuals who practice within the offices of North Fulton Treatment Center are bound by the same rules of confidentiality and we all operate as a single treatment team.
- I also may have the need to do business with outside entities, such as an accountant or lawyer. As required by HIPAA, I must have a formal business associate contract with these entities if they have access to PHI. In the associate contract these entities agree to maintain the confidentiality of PHI except as specifically allowed in the contract or otherwise required by law. Upon your request I will provide you with the names of the entities (if any) that have access to PHI and/or a blank copy of my business associate contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement (page 2 of 4).

There are some situations in which I am permitted or required by law to disclose information without your consent or authorization, as follows:

- If you threaten to harm yourself, I am obligated to seek hospitalization for you – either voluntarily or involuntarily and with the assistance of law enforcement; advise others of the potential for harm; and/or to contact family members or others who can help provide protection.
- If I am court ordered to disclose PMI I must submit the required information. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court might potentially order me to disclose information.
- If a government agency requests the information for health oversight activities, I may be required to provide it to them.
- If a patient files a complaint or a lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, and I am providing treatment related to the claim, I must submit, upon appropriate request, copies of all medical records and bills.
- If I have reason to believe that a child, a disabled adult, or an elder person has sustained physical injury or injuries other than by accidental means, or has been neglected or exploited, the law requires that I file a report with the appropriate governmental agency, usually the Department of Family and Children's Services (DFCS) or

the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.

- If I determine that a patient presents a serious danger to person(s) other than themselves or to property, I am required by law to take protective actions. These actions may include notifying the potential victim(s), contacting the police, contacting the Department of Homeland Security, and/or seeking hospitalization (voluntary or involuntary) for the patient.

While this summary of exceptions to confidentiality should prove helpful and informative, it is important that we discuss any questions or concerns that you may have, now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Professional Records
You should be aware that, pursuant to HIPAA, I keep PHI about you in a chart of professional records. This chart constitutes your Clinical/Medical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals we set for treatment, your progress toward those goals, your medical and social history, your treatment history, and past records that I receive from other providers, reports of any professional consultations, your billing records, and any report that have been sent to anyone, including your insurance carrier. Except in unusual circumstances [such that may involve danger to yourself or others or makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person or to your own well-being, or if information is provided to me confidentially by others] you or your legal representative may examine a copy of your Clinical Record, if you make a written request. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee and fees for certain other expenses. The exceptions to this policy are contained in the attached Georgia HIPPA Privacy

Patient Rights
HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of PHI. These rights include requesting that I amend your record; requesting restrictions on

what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to nor authorized; determining the location to which PHI disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you at any time.

Minors and Parents
Patients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child or we agree otherwise. Because privacy in therapy is crucial to therapeutic progress, particularly with teenagers, it is my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, I will only provide them with general information about the progress of the child's treatment and his or her attendance at scheduled sessions. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents my information, I will discuss the matter with the child, if possible, and do my best to address any concerns and handle any objections he or she may have.

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Billing and Payments
You are expected to pay for each session at the time it is held, unless we agree otherwise. Fees and payment schedules for other professional services will be agreed upon when they are requested. In certain cases of demonstrated financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for 60 days or more 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, both of which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his or her name, the nature of the services provided, and the amount due. If such legal action is necessary its costs will be included in the claim.

You are responsible for the full payment of all appointments not cancelled with at least 24-hour notice. Any balances on account are considered delinquent after two months and a 30% fee will be added to your balance due. After three months any unpaid balances are subject to submission to a collection agency.

I understand that I will be charged a missed appointment fee of $75.00 for any appointments not kept unless at least a FULL 24-HOUR notice (a 48-hour notice is required if cancellation is for a Monday appointment) is given to the clinician**.**

I consent for billing and treatment necessary for the care of the above-named patient. I have read, understand, and agree to the office policies, attached.

____ ________________________
Signature of Patient or Guardian Date

____
Please Print Patient Name

Please remember to call 911 in an emergency

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT, THAT YOU ACCEPT ITS TERMS AND CONDITIONS, AND, BY DOING SO THAT YOU GIVE CONSENT TO TREATMENT. THE SIGNATURE BELOW ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE GEORGIA HIPAA PRIVACY NOTICE FORM DESCRIBED ABOVE.

____ __________________
Patient Signature Date

____ __________________
Patient or Guardian Signature Date

(The information requested in this form will be kept confidential)

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CREDIT CARD ON FILE FOR SERVICES

Cardholder Name (as written on credit card): ____
Credit Card Billing Address:____
City, State & Zip: ____
Credit Card Type: □ Visa □ Mastercard □ Discover □ AmEx
Credit Card Number: ____
Expiration Date: ________________
Card Identification Number (CVV): ___________

I authorize Dianne S. Johnson, LCSW to charge to my credit card provided herein any amounts due on my account. I agree to have Dianne Stanford Johnson, LLC maintain my credit card information on file and automatically charge my credit card when payments are due. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement. I agree to inform Dianne S. Johnson, LCSW within 15 days of any changes in credit card information, and I agree to pay any fees in the event my credit card is declined.

Cardholder – Print Name, Sign and Date Below

Signed:_______________________________________

Date:____

Name:____

(The information requested in this form will be kept confidential)

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GEORGIA HIPAA PRIVACY NOTICE

Notice of Psychotherapist Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCEESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

I may *use* or *disclose* your *protected health information (PHI)* for *treatment, payment, and health care operations* purposes with your *consent.* To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment, and Health Care Operations"*
    - *Treatment* is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician, psychiatrist, or another therapist.
    - *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 of health care operations are quality assessment and improvement activities; business-related matters such as audits and administrative services; and case management and coordination of care.
- *"Use"* applies only to activities within my practice group (including all members and employees of Northwest Behavioral Medicine), such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure*" applies to activities outside my practice group such as releasing, transferring, or providing access to information about you to other parties.
-

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing information.

You may revoke all such authorizations 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. Law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

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

- *Child Abuse* – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.

- *Adult and Domestic Abuse* – If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.
- *Health Oversight Activities* - If I am the subject of an inquiry by the Georgia Composite Board or other licensing, credentialing, or certifying agency, I may be required to disclose PHI regarding you in proceedings before these agencies.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent 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* – if I determine, or pursuant to the standard of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.
- *Worker's Compensation* – I may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws related to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychotherapist's Duties

Patient's Rights:

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information. 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. On 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. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On you request, I will discuss with you the details of the request and denial 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 you request, I will discuss with you the details of the amendment process.
- *Right to Accounting* – You generally have the right to receive an accounting of disclosures of PHI. 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 this notice from me upon request, even if you have agreed to receive the notice electronically.

Psychotherapist's 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 substantially revise my policies and procedures I will notify you in writing within 30 days of the revision.

Dianne S. Johnson, LCSW
601 Bombay Lane, Roswell, GA 30076
Office: 404-576-8454 • Facsimile: 770-754-4676
www.diannesjtherapy.com

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please discuss your concerns with me openly so we may seek resolution. If resolution is not achieve to your satisfaction, you may also send a written complaint to the Secretary of the US Department of Health and Human Services. I will provide you with that address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice went into effect on February 7, 2003 in preparation for an April 14, 2003 deadline as mandated in the Privacy Rule.

Dianne Stanford Johnson, LLC reserves the right to change the terms of this notice and to make the new notice provision effective for all PHI information that is maintained. A written revised notice will be given to you within 30 days of the change in terms and conditions.

The undersigned patient or patient representative, has read, understood, and accepted this Privacy Notice. The undersigned patient or patient representative understands that a copy of this document is available upon request.

Signature of Patient or Guardian________________________________Date_______________

Printed Name____

(The information requested in this form will be kept confidential)

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CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide, and for other professional activities (known as "health care operations."). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. I reserve the right to revise the Notice of Privacy Practices at any time. If I do so, the revised Notice will be posted in the office. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

____ ____________________
Signature of Patient or Guardian Date

____
Please Print Patient Name

(The information requested in this form will be kept confidential)

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PAYMENT AGREEMENT

I only accept four health insurances at this time: BC/BS, UBH, Cigna, and Medicare. If I do not accept your health insurance, I can provide you with a superbill in order for you to file your insurance claim since I am an out-of-network provider. Individual appointments are $125.00 per 50 minute session. Additional fees are as follows:

- Missed or improperly cancelled appointments (including initial appointments) at $75.00 per incident
- Telephone consultations/telephone calls exceeding 10 minutes prorated based on $125.00 per 50-minute session
- Court costs at $150.00 per hour with an eight-hour minimum ($1200.00). Time required for preparation and travel time will be billed in addition to actual court time.
- Document preparation for legal purposes prorated based on $150.00 per hour –
    - Expedited (preparation within one week) requests add 100.00 flat fee
    - Rush (preparation within 72 business hours) requests add $300.00 flat fee
- Disability forms at $75.00 and up depending on complexity
- Professional consultations prorated based on $125.00 per 50-minute session
- Other requests requiring a significant investment of time to execute prorated based on $125.00 per 50-minute session

I authorize Dianne S. Johnson, LCSW or Dianne Stanford Johnson, LLC to charge my credit card on file, for services as described on a per instance basis.

Signature______________________________________

(The information requested in this form will be kept confidential)