

# Charlotte Counseling

Dr. Dorothy McCoy

2016



I look forward to meeting you and moving with you toward your goals. It will be an interesting and sat

Dr. Dorothy McCoy  
2015 Ayrsley Town Blvd.  
Suite 202  
Charlotte, NC 28273  
803-465-0191

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*Licensed Professional Counselor North and South Carolina  
National Certified Counselor  
Certified Cognitive – Behavioral Therapist  
Diplomat, the American Academy of Experts in Traumatic Stress  
Member, Society of Police and Criminal Psychology  
Member, American Counseling Association  
EMDR Trained  
NOVA Trainer of Trainers  
Published Author*

Welcome to counseling! I look forward to meeting you in person. Please take a few minutes to complete this form and bring it with you to our first session. Thank you☺

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_

E.Mail \_\_\_\_\_

Spouse's (significant other) Name \_\_\_\_\_

Married\_\_\_\_ Single\_\_\_\_ Divorced\_\_\_\_ Separated\_\_\_\_ Relationship\_\_\_\_\_ Children \_\_\_\_\_

Referred by \_\_\_\_\_

Family Doctor \_\_\_\_\_ Employer \_\_\_\_\_

How may we contact you for appointments or information? Which way would you rather be contacted: E-mail\_\_\_\_ Phone \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_

# Dr. Dorothy McCoy

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## Informed Consent for Charlotte Counseling

I hereby voluntarily apply for and consent to counseling services provided by Dr. Dorothy McCoy. This consent applies to me, a child, ward, or client named below. Because I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent.

### **Degree and Certification**

Dr. Dorothy McCoy graduated from the University of South Carolina in 1986. Her Masters Degree in Clinical Counseling is from The Citadel, 1990. She received her Doctorate in Counseling Psychology from the University of Sarasota in 2001. She is licensed by the State of South Carolina as a Licensed Professional Counselor (#1915) and a Licensed Professional Counselor in North Carolina (#9295). She is a National Certified Counselor (18883), after passing the examination, completing supervision hours, and client contact hours as required by NCC. She must complete further hours of continuing education every two years to remain licensed. She is also a Diplomate with the American Academy of Experts in Traumatic Stress a member of the American Counseling Association, The Society for Police and Criminal Psychology, and International Consortium on Public Safety Leadership (through Police Futurists). She became board certified after completing the necessary requirements to establish an expertise in the area of trauma. She is a NOVA (National Organization for Victims Assistance) certified community crisis responder and certified trainer.

She was a member of ISTSS (International Society for Traumatic Stress Studies) and presented a paper at their international conference in Edinburgh, Scotland in 2001.

### **Population Served**

Dr. McCoy sees clients over 15 years of age, unless a younger child is seen as a member of a family in counseling. She works with depression, anxiety, couples issues, trauma related issues, weight-loss, anger management, stress management, behavior change, law enforcement officers' issues and veterans' issues. She is the author of several traditionally published books (The Manipulative Man 2006, From Shyness to Social Butterfly 2003, The Ultimate Book of

Personality Tests 2005, and Brain Games-Personality Quizzes 2008) published in three languages.

### **Theoretical Orientation and Techniques and Approach to Therapy**

Dr. McCoy is a Cognitive-Behavioral Therapist; however, she also uses techniques from Humanistic Theory, Brief Therapy, EMDR, Motivational Interviewing and Gestalt Theory. Cognitive theory is based on the assumption that we largely create our world based on our beliefs and perceptions. Therefore, a cognitive therapist will want to understand the client's thoughts and beliefs, to examine them with the client for accuracy and functionality, and to restate them, if necessary, in more adaptive ways. The ideal outcome is to open new options for the client. The client can then decide whether to make changes or not. The client's right to choose is always respected. Techniques may include asking the client to keep a journal, listen to a relaxation CD or tape, learn a new skill (i.e., assertiveness), read a book, write a story or role-play.

You normally will be the one who decides therapy when will end, with two exceptions. If we have contracted for a specific short-term piece of work, we will finish therapy at the end of that contract. If I am not in my judgment able to help you, because of the kind of problem you have or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs.

### **Limitations of Services**

I understand that Dr. McCoy's services are limited to assessment, consultation, and intervention. I understand that intervention services may include counseling and brief psychotherapy. I understand that Dr. McCoy is not warranting a cure or offering any guarantee of results or improvement in any condition.

### **Session Duration and Fee**

The therapy session will last for approximately 50 minutes. New clients will sometimes be seen for 80 minutes in order to gather the necessary information and to address the client's concerns. The fee for a 50-minute session is \$125.00 and the fee for an 80-minute session is \$175.00. If the client has insurance this office will be happy to help him/her apply for reimbursement. Because there are so many plans, of which we are unfamiliar, we ask that payment be made at the end of the session.

EAP clients will not be responsible for their bill at the time of their appointment, if arrangements have been made by their EAP for payment.

Reports for a third party are charged at a flat rate of \$200 unless the report is particularly time consuming.

## **Diagnosis**

If payment is made by a third party (i.e., EAP, insurance), or a report is required by you, for your attorney or another third party, they often require a diagnosis. Under these circumstances the diagnosis becomes a permanent part of your record with this office, and the third party to which it is sent. This is covered in more detail later in this document. Frequently, a diagnosis is not given when clients are self-pay, unless the client asks for one (and no third party report is requested).

## **Assumption of Risks**

I understand that potential benefits of undergoing counseling services may include obtaining a professional opinion and an increased understanding. I understand that potential risks may include limited predictive validity of assessment procedures, possible disagreement with the opinions offered to me, and possible emotional distress concerning my situation. I understand that alternative procedures include services provided by another counselor, psychologist, psychiatrist, or mental health professional.

## **Limits of Confidentiality (From Code of Ethics and Standards of Practice (ACA, 2005))**

I understand and agree that my disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information or under certain other conditions listed below. I understand that confidential and privileged information may be released without my consent or authorization in the following circumstances recognized by the ACA Guidelines (2005):

A breach of confidentiality may be required when there is:

- Child or elder abuse or neglect
- Danger to the client or identified others
- Danger of contagion of life-threatening diseases
- A court order for disclosure
- Involvement of a DSS worker or guardian ad litem,
- A request for information from the parent of a minor child
- If you initiate a complaint or litigation against your therapist

## **Minimal Disclosure**

To the extent possible, you will be informed before confidential information is disclosed and are involved in the disclosure decision-making process. When circumstances require the disclosure of confidential information, only essential information is revealed.

## **Couples**



**Moods (Check all that apply)**

Depressed\_\_\_\_Anxious or Nervous\_\_\_\_Guilty\_\_\_\_Angry\_\_\_\_  
Happy\_\_\_\_Irritable\_\_\_\_

**Physical Symptoms (Mark all that apply)**

Fatigue\_\_\_\_ Feeling of Choking\_\_\_\_ Tics or Tremors \_\_\_\_  
Dry Mouth\_\_\_\_ Chest Pain\_\_\_\_ Shaking/Nervous\_\_\_\_  
Chest Pain\_\_\_\_Faint\_\_\_\_Peculiar Taste in Mouth\_\_\_\_Light headed\_\_\_\_  
Nausea\_\_\_\_Sexual Difficulty\_\_\_\_Peculiar Smells Noticed\_\_\_\_  
Dizziness\_\_\_\_Chills/Hot flashes\_\_\_\_Restlessness\_\_\_\_Heart Palpitations\_\_\_\_  
Muscular Weakness\_\_\_\_Fast Heart Rate\_\_\_\_Sudden Bursts of Energy\_\_\_\_  
Difficulty Breathing\_\_\_\_Can go days without Sleeping\_\_\_\_

**Have you ever had?**

Head Injury\_\_\_\_Poor circulation\_\_\_\_Cancer\_\_\_\_Hyper/Hypo Thyroidism\_\_\_\_  
Amnesia\_\_\_\_High Blood Pressure\_\_\_\_Diabetes\_\_\_\_Allergies\_\_\_\_Blackouts\_\_\_\_  
Heart Disease\_\_\_\_Stroke\_\_\_\_

**Behavioral /Emotional (check all that apply)**

Avoid Certain Situations\_\_\_\_Worry Excessively\_\_\_\_Angry Outbursts\_\_\_\_  
Difficulty Working\_\_\_\_Withdraw from others\_\_\_\_“See Things”\_\_\_\_  
Repetitive Behaviors\_\_\_\_Crying bouts\_\_\_\_Fears\_\_\_\_“Hear Things”\_\_\_\_  
People trying to harm you\_\_\_\_Sudden mood swings\_\_\_\_Binge eating\_\_\_\_  
Little or no interest in sex\_\_\_\_Reluctance to leave home\_\_\_\_Pain during sex\_\_\_\_

Feeling losing control\_\_\_\_\_Lost interest in previously enjoyable activities\_ Forget things more\_\_\_\_\_Sudden anxiety attacks\_\_\_\_\_Disoriented\_\_\_\_\_ Relationship Problems\_\_\_\_\_Procrastinating\_\_\_\_\_Concern with weight\_\_\_\_\_  
Feel compelled to do things\_\_\_\_\_Lose periods of time\_\_\_\_\_

When was the last time you felt just the way you wanted to feel?

\_\_\_\_\_

What would you like to be different in your life?\_\_\_\_\_

\_\_\_\_\_

Do you have any conditions for which you are taking medication?

\_\_\_\_\_

\_\_\_\_\_

Have you seen a therapist before? Y\_\_\_N\_\_\_ Who?\_\_\_\_\_

What was the issue for which you sought therapy?

\_\_\_\_\_

\_\_\_\_\_

Did you find the therapy helpful? Y\_\_\_N\_\_\_

You have been married (in relationship) for how long? \_\_\_\_\_

What would you like to be different in your life (what is your goal for therapy)?\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Please answer the following questions with Y or N:

- I am often very tired, even without much activity. Y N
- I often cry. Y N
- My appetite has changed in the last six months. Y N
- I have lost or gained weight in the last six month. Y N
- I no longer enjoy activities that once brought pleasure to me. Y N
- I see family and friends less often than I did. Y N
- I sometimes see the future as hopeless. Y N
- I sometimes see myself as hopeless. Y N
- I feel close to three or more people. Y N
- I believe my marriage (relationship) is a good. Y N
- I have fun (do things just for fun) at least once a week Y N
- I would call myself a sad person. Y N
- I like the way my body looks. Y N
- I would call myself a successful person. Y N
- I have a good relationship with my mother. Y N
- I have a good relationship with my father. Y N
- There has been an important change in my life recently. Y N
- Others would describe me as a warm person. Y N
- I worry a lot about my weight, or about gaining weight. Y N
- It is sometimes hard for me to stop eating, especially junk food. Y N
- I have recently started a new medication. Y N
- I take the following medications:

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- I exercise at least twice a week. Y N
- I take vitamins. Y N I often eat balanced meals. Y N
- I am bothered by nightmares or flashbacks. Y N
- The things I fear the most are:

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- At all cost I want to avoid:

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- I would enjoy my marriage or relationship more if my partner would.

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- 
- My partner would enjoy our relationship more if I would. (Please do not ask your spouse, I would like your opinion.)
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- I have considered suicide. Y N
  - I have formed a plan for suicide. Y N
  - I think I am likely to commit suicide. Y N
  - I am sometimes so full of energy I find it difficult to sleep at night. Y N
  - I try to avoid friction and arguments, even if a problem remains unresolved. Y N
  - I always face problems and look for solutions. Y N
  - I enjoy doing things that I find exciting. Y N
  - I have had an unpleasant sexual experience. Y N
  - I have, at sometime in my life, been physically harmed. Y N
  - I startle easily. Y N
  - Sometimes my heart pounds and I feel lightheaded. Y N
  - I have changed jobs recently. Y N
  - I have had more than three jobs in the last two years. Y N
  - People always seem to disappoint me. Y N
  - Making friends is easy for me. Y N
  - I find it difficult to trust people. Y N
  - I like myself. Y N
  - Normally, I like other people. Y N
  - Often, I want to just stay in bed all day. Y N
  - I have been told that I drink more than I should. Y N
  - I often spend more money than I can afford. Y N
  - I have experienced a trauma in my life. Y N
  - I feel confused or have difficulty concentrating several times a week. Y N
  - To understand me you need to know
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Thank you for taking the time to complete this questionnaire. Be assured that your comfort is important to me; therefore, share only the information you are comfortable sharing. Again, welcome to counseling.

How may we contact you for appointments or information?

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Signature \_\_\_\_\_ Date \_\_\_\_\_

**BY LAW** I am required to ensure that your Protected Health Information is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose you PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not sue or disclose more of you PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in the Notice.

Please note that I reserve the right to change the terms of the Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I made any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office and on my website. You may also request a copy of this Notice from me.

### **III. HOW I WILL USE AND DISCLOSE YOU PHI**

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

#### **A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent, I may use and disclose your PHI without your consent for the following reasons**

- 1. For treatment:** I may disclose your PHI to physicians, psychiatrist, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.
- 2. For health care operations:** I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control – I might use your PHI in the evaluation of the quality of health care services that you have received or to

evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

**3. To obtain payment for treatment:** I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you, Examples: I might send you PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide you PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

**4. Other disclosures:** Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

**B. Certain Other Uses and Disclosures Do Not Require Your Consent.** I may use and/or disclose your PHI without your consent or authorization for the following reasons:

**The following list is a compilation of federal laws.....**

- 1.** When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
- 2.** If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
- 3.** If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
- 4. To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.
- 5.** If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
- 6. If disclosure is mandated by the Elder/Dependent Adult Abuse Reporting law.** For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
- 7.** If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonable identifiable victim or victims.
- 8. For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
- 9. For health oversight activities.** Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.

10. **For specific government functions.** Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
11. **For Workers' Compensation purposes.** I may provide PHI in order to comply with Workers' Compensation laws.
12. **Appointment reminders and health related benefits or services.** Examples: I may use PHI to provide appointment
13. **If an arbitrator or arbitration panel compels disclosure,** when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
14. **If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.** Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
15. If disclosure is otherwise specifically required by law.

**C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.**

1. **Disclosures to family, friends, or others.** I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

**D. Other Uses and Disclosures Require Your Prior Written Authorization.** In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

**IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI**

These are your rights with respect to your PHI:

- A. The Right to See and Get Copies of Your PHI.** In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of you PHI, I will charge you not more than \$.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it as well as to the cost, in advance.
- B. The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not

legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

- C. The Right to Choose How I Send Your PHI to You.** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.
- D. The Right to Get a List of the Disclosures I Have Made.** You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, send directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.
- E. The Right to Amend Your PHI.** If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your HI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.
- F. The Right to Get This Notice by Email.** You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

#### **V. HOW TO COMPLAIN ABOUT MY PRIVATE PRACTICES.**

If, in your opinion, I may have violated your privacy rights, or if you object to a Decision I made access to your PHI, you are entitled to file a complaint as stated earlier. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy Practices, I will take no retaliatory action against you.

#### **VI. EFFECTIVE DATE OF THIS NOTICE.**

This notice went into effect on April 14, 2003. I acknowledge receipt of the notice.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**PATIENT STATEMENT**

I will be involved in developing my treatment plan. I agree to follow my treatment plan or ask for a conference to revise the plan. I will do homework as agreed because it is an essential part of my treatment. I will keep appointments as scheduled unless there is an unavoidable reason for rescheduling. I will call 24 hours in advance (when possible) to reschedule or I will be responsible for the fee of \$25.00

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES OF**

Dr. Dorothy McCoy

**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.**

Date \_\_\_\_\_

If you have any questions or requests about this Notice, please contact Dr. Dorothy McCoy.

State and Federal law require that the Practice maintain the privacy of protected health information.

"Protected health information" is information the Practice has created or received about your physical or mental health, the healthcare provided to you or payments for your healthcare if the information identifies you, or if a reasonable person would say that someone could use it to identify you. It includes your identity, diagnosis, dates of service, treatment plan, and progress in treatment.

In addition, the law requires that the Practice provide clients with this Notice of Privacy Practices. It explains our legal duties and privacy practices with respect to your medical and mental health information. It is also required to request that you sign the attached written acknowledgement that you received a copy of this Notice. This Notice describes how the Practice may use and disclose your protected health information.

This Notice also describes your rights regarding your protected health information and explains how you may exercise your rights.

## USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

### Permissible Uses and Disclosures Not Requiring Your Written Authorization

The Practice may use and disclose your medical and mental health information in the following ways:

**Treatment:** The Practice may use and disclose your medical and mental health information to provide and coordinate your healthcare. The Practice may use or disclose your medical and mental health information when I consult with another professional colleague, if I refer you for medication, or when I arrange coverage for being away. In any of these situations, we will provide only the minimum information necessary.

**Payment:** The practice will use your mental health care information for accounting and billing. If you consent, we will provide the minimum necessary information to your insurance company or other third party payer. The information can include information that identifies you, your diagnosis, dates and type of service, and limited information about your condition and treatment.

**Health Care Operations:** The Practice may use and disclose your medical and mental health information for health care operations, including quality improvement activities, training programs, and obtaining legal services. I will only disclose necessary information.

**Required or Permitted by Law:** The Practice may use or disclose your medical and mental health care information when I am required or permitted to do so by law or for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or to take action regarding imminent danger to others; (d) when the client is a danger to self or others or gravely disabled; (e) when a coroner is investigating the client's death; or (f) to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, or regulatory compliance.

**Contacting the Client:** You may be contacted to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.



Crimes on the premises or observed by the provider: Crimes that are observed by the therapist or the therapist's staff, crimes that are directed toward the therapist or the therapist's staff, or crimes that occur on the premises will be reported to law enforcement.

Business Associates: Business associates may provide some of the functions of the practice. For example, business associates may provide some of the billing, legal, auditing, and practice management services. In those situations, the Practice will provide only necessary protected health information to those contractors as needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.

Involuntary Clients: Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.

Family Members: Except for certain minors, incompetent clients, or involuntary clients, the Practice cannot provide protected health information to family members without the client's consent. In situations where family members are present during a discussion with the client, and it is reasonable to infer from the circumstances that the client does not object, I may disclose information in the course of the discussion. However, if the client objects, I will not disclose protected health information.

Emergencies: In life-threatening emergencies, the Practice will disclose information necessary to avoid serious harm or death.

Uses and Disclosures Requiring Your Written Authorization or Release of Information Except as described above, or as permitted by law, other uses and disclosures of your medical and mental health information will be made only with your written authorization to release the information. When you sign a written authorization, you may later revoke the authorization in writing as provided by law.

However, that revocation may not be effective for actions already taken under the original authorization.

Psychotherapy Notes: Psychotherapy notes are maintained separate from your mental health record. These notes will be used only by your therapist and disclosure will occur only under these circumstances: (a) you specifically authorize their use or disclosure in a separate written authorization; or (b) the therapist who wrote the notes uses them for your treatment; or (c) they may be used for training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills; or (d) if you bring a legal action and we have to defend ourselves; and (e) certain limited circumstances defined by the law.

**YOUR RIGHTS AS A CLIENT**

**Additional Restrictions:** You have the right to request additional restrictions on the use or disclosure of your medical and mental health information. However, the clinician does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. Ask your clinician for the Request Form. Request that you receive communications from the practice by alternative means or at alternative locations. For example, you may request that bills and other correspondence be sent to an address other than your home address. Ask your clinician for the Request Form.

**Access to Protected Health Information:** You have the right to inspect and obtain a copy of your protected health information in the mental health and billing record. However, any psychotherapy notes are for the use of your therapist, and are treated differently. If it is thought that access to your mental health records would harm you, your access may be restricted. Ask your clinician for the Request Form and the appeal process.

**Amendment of Your Record:** You have the right to request an amendment or correction to your protected health information. If the clinician agrees that the amendment or correction is appropriate, the Practice will attach it to the record. An appeal process is available if the clinician determines the record is accurate and complete as is. Ask your clinician for the Request Form and the appeal process available to you.

**Accounting of Disclosures:** You have the right to receive an accounting of certain disclosures the practice has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment payment and healthcare operations. In addition, the accounting does not include disclosures made to you, disclosures authorized by you, or disclosures made prior to April 14, 2003. Other exceptions will be provided to you, should you request an accounting. Ask your clinician for the Request Form.

**Right to Revoke Consent or Authorization:** You have the right to revoke your consent or authorization to use or disclose your medical and mental health information, except for action that has already taken place under your consent or authorization.

**Copy of this Notice:** You have a right to obtain a copy of this Notice upon request.

The Practice is required to abide by the terms of this Notice, or any amended Notice that may follow. The Practice reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that it maintains. When changes are made, the revised Notice will be posted at the Practice's office and copies will be available upon request.

If you believe the Practice has violated your privacy rights, you may file a complaint with the person designated within the Practice to receive your complaints, \*(that is your clinician or the Privacy Officer).

You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Bldg., Washington, D.C. 20201. It is the policy of the Practice that there will be no retaliation for your filing of such a complaint.

Appendix B: Acknowledgement of Receipt of Notice of Privacy Rights (Required)

Dr. Dorothy McCoy

Acknowledgement of Receipt of Notice of Privacy Rights

I, \_\_\_\_\_, Client Name acknowledge that I received a copy of the Notice of Privacy Practices for Dr. Dorothy McCoy.

Signature of Client or Personal Representative Date :

\_\_\_\_\_

If not the client, please print name and state legal authority to sign for client.

I will be happy to appear in court, my charge is \$2000. Please sign here that you have read this. Thank you!

Signature of Client

\_\_\_\_\_

=== For Practitioner Use Only ===

I attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining acknowledgement
- Client was incapable of signing
- Other (Specify)

\_\_\_\_\_

Signature of Practitioner \_\_\_\_\_

Date \_\_\_\_\_

