

FRAME OF MIND CLINIC LLC

6540 S Pecos Road Building A, Suite 103A

Las Vegas, Nevada 89120

Office: (725) 726-8216 Fax: (725) 726-8633

All highlighted fields are required.

Date: _____

Full Patient Name: _____ DOB: _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____

Check Appropriate Description:

Gender: Male / Female / Decline to Specify **Marital Status:** Single / Married / Divorced / Widowed / Legally Separated

Race: White / African American / Asian / Pacific Islander / Other / Decline to Specify

Ethnicity: Hispanic / Non-Hispanic / Decline to Specify

Patient Employer: _____ Occupation: _____ Phone: _____

Emergency Contact (In case of an emergency or if unable to contact you, whom may we notify or leave a message with)

Name: _____ **Relationship:** _____ **Phone:** _____

Insurance:

Primary Policy

Name of policy holder: _____ DOB: _____ Social Security # _____

Address if different from patient: _____

Insurance Company: _____ Policy ID #: _____ Effect. Date: _____

Secondary Policy

Name of policy holder: _____ DOB: _____ Social Security # _____

Address if different from patient: _____

Insurance Company: _____ Policy ID #: _____ Effect. Date: _____

IF THE PATIENT IS NOT THE PERSON TO BE BILLED, PLEASE COMPLETE THIS SECTION:

Dependent is a: Adult Child Spouse

Responsible Party Name: _____ Relationship to Patient: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Signature of Responsible Party: _____

Pharmacy:

Name: _____ Address: _____ Phone: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

By signing below, I hereby acknowledge receipt of Frame of Mind Clinic LLC's Notice of Privacy Practices and consent to the uses and disclosures described in the Notice of Privacy Practices.

Signature of Patient Date: _____

Signature of Parent/Guardian/Legal or Personal Representative

(Please Indicate your legal authority to act for this patient) _____

AUTHORIZED PERSONS TO ACCESS MY INFORMATION:

	<u>Name</u>	<u>Relationship</u>	<u>Phone Number</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Signature of Patient Date: _____

Signature of Parent/Guardian/Legal or Personal Representative

**CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION
AND RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, _____, (Name of Patient, Legal or Personal Representative), hereby give my consent to Frame of Mind Clinic LLC to use or disclose for the purpose of carrying out treatment, payment or healthcare operations, basic information contained in patient record of patient indicated above.

I understand that by law and professional ethics, what is shared in psychotherapy remains confidential unless permission has been given to share it, or except as the law of my managed care company requires.

I consent a release of basic identifying information and the amount of the unpaid balance to a collection service or an attorney for purposes of collecting a debt if this becomes necessary.

I understand and consent to the release of information about my condition and care (including access to my chart) to the managed care company for their review for purposes of payment or quality assessment. If seeing a therapist opposed to a Psychiatrist, I understand that some insurance companies require therapists be supervised by a psychiatrist. I understand the supervision will involve a review of the treatment plan and confidential discussion of my progress.

I understand and consent to the release of information about my condition and care (including access to my chart) to all the providers, both doctors and therapists, of Frame of Mind Clinic. I understand that they provide on-call coverage for each other as well as for continuity of care should I see multiple providers within Frame of Mind Clinic LLC.

I acknowledge receipt of Frame of Mind Clinic LLC's Notice of Privacy Practices and consent to the uses and disclosures therein.

I understand that Frame of Mind Clinic reserves the right to change the privacy practices described and that a copy of any revised notice will be made available to me at my next visit.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent by giving written notice of my desire to do so to my provider. I also understand that I would not be able to revoke this consent in cases where the provider has relied on it to disclose my health information.

CONSENT FOR TREATMENT AND FINANCIAL POLICY

TREATMENT: You and your clinician will work together to identify treatment goals and options. The length of time in treatment you will receive will vary according to individual needs and will be discussed throughout the course of your care. You are encouraged to talk as openly as possible about problems you are experiencing so that your clinician can better assist you in treatment planning. Your clinician will inform you about treatment options and will include potential benefits and risks associated with those options. You do have rights to refuse treatment. As mental health treatment is an exact science, no guarantees can be made as to the success of such treatment.

PAYMENT POLICIES: We accept cash, personal checks, and most major credit cards. Payment of copays, deductibles and self-pay rates are due at the time of service.

Frame of Mind Clinic LLC schedules appointments by a block of time for each patient. If you are unable to attend your scheduled appointment, please notify staff 24 hours prior to our scheduled time.

As insurance is a contract between you and your carrier, you are ultimately responsible for payment of all charges. You must provide proof insurance at the time of your initial visit and are responsible for providing the office with changes in insurance coverage. Failure to do so may result in denial of your claim. As a matter of courtesy to our patients, we will submit charges to your insurance company. Any amount that your insurance company will not be paying such as copays, coinsurances and deductibles are due at the time the service is rendered. If your insurance company has not paid within

sixty days or denies coverage, the balance will be billed to you for immediate payment. If you do not have insurance, payment in full is required at the time of service.

Some managed care companies require the patient to get prior approval and an authorization for their visit. If you fail to get necessary prior approval for your visit, payment in full is required at the time of service.

If a patient's bill remains unpaid, Frame of Mind Clinic LLC reserves the right to provide your name, basic identifying information and the amount of the unpaid balance to a collection service or an attorney.

ASSIGNMENT OF BENEFITS: Insurance Authorization/Release: By signature below, I hereby authorize Frame of Mind Clinic LLC to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company; to pursue rightful collection of monies owed by my insurance company and services rendered until the companies responsibility has been satisfied or all appeal efforts have been exhausted and thereby authorize payment of the insurance benefits directly to Frame of Mind Clinic LLC for any and all services rendered.

MEDICARE AUTHORIZATION/RELEASE: By signature below, I request that payment of authorized Medicare benefits be made on my behalf to Frame of Mind Clinic LLC for any and all services rendered to me by their providers. I hereby authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services and its agents to any information needed to determine these benefits or the benefits payable for related services.

My signature below indicated that I have read and understand the foregoing information relative to my responsibility for the services provided as well as authorizing the release of medical information as required to process claims and benefits to which I am entitled.

Signature of Patient **Date:** _____

Signature of Parent/Guardian/Legal or Personal Representative **Date:** _____

AUTHORIZATION FOR APPOINTMENT REMINDER / INFORMATION SERVICE

Patient Name: _____ DOB: _____

Address: _____

I hereby authorize Frame of Mind Clinic LLC, to contact me in order to remind me of upcoming appointments and inform me of any pertinent information surrounding my appointment.

☐ Telephone: _____

☐ Text: _____

☐ Email: _____

If the above number/address changes, I understand that it is my responsibility to contact Frame of Mind Clinic to change my information so it does not get delivered to an unauthorized party.

Frame of Mind Clinic LLC schedules appointments by a block of time for each patient. If you are unable to attend your scheduled appointment, please contact our office 24 hours prior to the appointment. Please allow for ample time for visits with your provider in the event a situation arises that causes your appointment to be pushed back due to unforeseen circumstances.

I understand that only information regarding my appointments and pertinent information will be delivered and that my information will not be given to a third party.

Signature of Patient **Date:** _____

Signature of Parent/Guardian/Legal or Personal Representative **Date:** _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Full Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

I (WE) Hereby authorize Frame of Mind Clinic LLC Phone: (725) 726-8216 Fax: (725) 726-8633

To: _____ Release _____ Exchange _____ Receive records or information as requested below

Agency/Person: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip: _____

Nature of Information to be disclosed: (Please check all that apply)

☐ Initial Psychiatric History/ Evaluation	☐ Lab/X-Ray/ Test results
☐ Progress Notes	☐ Financial Information
☐ Psychological Reports/Evaluations	☐ Consultations
☐ Complete Medical Record	☐ Contact/Discuss Treatment and Progress
☐ Other _____	☐ All Information

For Purpose of: (Please check all that apply)

☐ Continuing (mental health/ alcohol and drug abuse) treatment, care and continuity of care	☐ Therapist Transition
☐ Billing and Payment related matters	☐ Other _____
☐ Legal	

This consent is valid for one year from date signed (unless otherwise specified). Other date: _____.

I understand that I may revoke this authorization by notifying **Frame of Mind Clinic LLC at 6540 S Pecos Road Building A, Suite 103A, Las Vegas Nevada 89120** in writing of my desire to revoke release prior to its expiration except to the extent that action has already been taken by Frame of Mind Clinic in reliance on consent.

I understand that Frame of Mind Clinic may not condition treatment or quality of care upon completion of this form. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization which will prevent disclosure of information.

I understand that Frame of Mind Clinic may, directly or indirectly, receive remuneration from another party in connection with the use or release of disclosed health information. I understand that I will be charged for review and copying of records.

I understand that the information disclosed may be subject to re-disclosure by the person(s) receiving it and will no longer be protected by the federal privacy regulations.

I have read and understand the terms of this authorization and release and have had an opportunity to ask questions about the use and disclosure of my health information. By signature, I knowingly and voluntarily authorize Frame of Mind Clinic to use or disclose my health information in the manner described above.

_____ Signature of Patient	_____ Signature of STAFF MEMBER
_____ Date	_____ Date

NOTICE TO PATIENT AND RECEIVING AGENCY:

Under the provisions of the Mental Health and Developmental Disabilities Confidentiality Act and applicable Federal and State Alcohol Substance Abuse Confidentiality Acts, there may not be disclosure of any of the information provided pursuant to this release unless the patient and/or parent of the patient specifically authorizes such disclosure.

Telehealth Consent Form

INFORMED CONSENT FOR TELEMEDICINE SERVICES

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. Frame of Mind Clinic LLC has explained the alternatives to my satisfaction,
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform Frame of Mind Clinic LLC of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I attest that I am located in the state of Nevada and will be present in the state of Nevada during all telehealth encounters with Frame of Mind Clinic LLC.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I understand a copy of this form will be available for me to print.

I hereby authorize Frame of Mind Clinic LLC to use telemedicine in the course of my diagnosis and treatment.
By checking this box, I agree to use electronic records and signatures.

Please type your name to sign below

Date

OFFICE POLICIES

Medication Refills:

Initial: _____ • It is your responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to seven (7) business days so please be courteous and do not wait to call. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.

Initial: _____ • Medication refills will only be addressed during these business hours (**Monday-Thursday 8am-4:30pm**). Please notify your provider on the next business day if you find yourself out of medication after hours.

Initial: _____ • Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.

Initial: _____ • Some medications require prior authorization. Depending on your insurance this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible, this process **can take up to 7-10 business days**. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication.

Initial: _____ • It is important to keep your scheduled appointment to ensure that you receive timely refills. All prescriptions require a follow up appointment every 3 to 6 months.

Form Fess:

Initial: _____ • Our office requires a \$150.00 form fee for any documents or forms filled out by our providers excluding some insurances plans that already cover this service. Please ask a staff member for more information.

Adolescent Appointments:

Initial: _____ • If you are the legal parent/guardian of a minor patient (under the age of 18) seen at Frame of Mind Clinic, you and the patient must be present during every in person and virtual visit and it cannot be done in separate locations at one time. If both the legal parent/guardian and the patient are not present, the appointment will be canceled and there will be a \$50.00 fee for a missed appointment.

Missed Appointments:

Initial: _____ • Our office requires a 24-hour cancelation or reschedule notice. Our office reserves the right to charge a \$50.00 penalty fee for any late cancelations or missed appointments which is not covered by insurance. In the event that any patient has three (3) or more late cancelations, late reschedules, or missed appointments within a calendar year, our office shall have the absolute right to discharge such patient.

Late Arrivals:

Initial: _____ • If you are late for your appointment, there is not a guarantee that you will be seen and will result in a no-show fee and reschedule.

Discharge Policy:

Initial: _____ • Our office reserves the right to discharge any patient from our practice for failure to abide by our Office Policies, Financial Policy, or any of the following: irreconcilable personality conflicts; habitual verbalization of dissatisfaction with our Office Policies; abusive language or behavior directed towards staff; disruptive behavior that interferes with our practice or other patients; destructive behavior that damages office property; use of profanity towards staff, providers or other patients of the practice; habitual disregard of a provider's plan of care and/or treatment plan; habitual failure to return emails or phone calls, or otherwise making it difficult to communicate about your health and

well-being; misuse, or the suspicion of misuse, of prescription medication; and engaging in and/or attempting to commit insurance fraud. All patient discharges are considered with great care, we do not make these decisions lightly. If you are discharged from the practice, you will be notified in writing via certified mail to the address on file with the office. To ensure continuity of care and to afford the discharged patient with ample time to arrange for a new psychiatrist, our office will ensure that the discharged patient has a 45-day supply of his/her current medications and the practice will remain available to provide psychiatric treatment to the discharged patient, on an emergency basis only, during the 45-day window after notice of discharge.

Patient Code of Conduct:

Initial: _____ • To provide a safe and healthy environment for staff, visitors, patients and their families, our office expects visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients, visitors and staff of the practice including, but not limited to the following: intimidating or harassing staff or other patients; making threats of violence through phone calls, letters, voicemail, email or other forms of written, verbal or electronic communication; physical assault or threatening to inflict bodily harm; making verbal threats to harm another individual or destroy property; damaging office equipment or property; making menacing or derogatory gestures to staff or other patients; use of profanity towards, staff, providers or other patients; and making racial or cultural slurs or other derogatory remarks towards staff, providers or other patients. If you are subjected to any of these behaviors or witness inappropriate behavior, please report the same to the office manager. Any individual's failure to comply with the office's Patient Code of Conduct will be subject to removal from the office and/or discharge from the practice

OFFICE USE ONLY:

Signature of **STAFF MEMBER**

Date

FRAME OF MIND CLINIC LLC PATIENT RIGHTS & RESPONSIBILITIES

(PLEASE RETAIN A COPY FOR YOUR RECORDS)

- Patients have the right to be treated with personal dignity and respect.
- Patients have the right to care that is considerate and respects member's personal values and belief system.
- Patients have the right to personal privacy and confidentiality of information.
- Patients have the right to receive information about managed care company's services, practitioners, clinical guidelines, and patient rights and responsibilities
- Patients have the right to reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.
- Patients have the right to participate in an informed way in the decision-making process regarding their treatment planning.
- Patients have the right to discuss with their providers the medically necessary treatment options for their condition regardless of cost or benefit coverage.
- Patients have the right of members' families to participate in treatment planning as well as the right of members over 12 years old to participate in such planning.
- Patients have the right to individualized treatment, including
 - Adequate and humane services regardless of the source(s) of financial support,
 - Provision of services within the least restrictive environment possible,
 - An individualized treatment or program plan,
 - Periodic review of the treatment or program plan, and
 - An adequate number of competent, qualified, and experienced professional clinical staff to supervise and carry out the treatment or program plan.
 - Resolving conflict,
 - Withholding resuscitative services,
 - Forgoing or withdrawing life-sustaining treatment, and
 - Participating in investigational studies or clinical trials.
- Patients have the right to participate in the consideration of ethical issues that arise in the provision of care and services, including
- Patients have the right to designate a surrogate decision-maker if the member is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care.
- Patients and their families have the right to be informed of their rights in a language they understand
- Patients have the right to voice complaints or appeals about managed care company or the care provider.
- Patients have the right to make recommendations regarding managed care company rights and responsibilities policies.
- Patients have the right to be informed of rules and regulations concerning patients' conduct.
- Patients have the responsibility to give their provider and managed care company information needed in order to receive care.
- Patients have the responsibility to follow their agreed upon treatment plan and instructions for care.
- Patients have the responsibility to participate, to the degree possible, in understanding their behavioral health problems and developing with the provider mutually agreed upon treatment goals.

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 Notice describes the privacy practices of Frame of Mind Clinic LLC (FMHS) and all business associates with whom we may share your protected health and medical information.

We understand that your medical or PHI ("protected health information") is confidential and we are committed to maintaining its privacy. Federal law requires that we provide you with this Notice of our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this Notice when we use or disclose your PHI and are also required by law to notify you if you are affected by a breach of your secured PHI.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION OR PHI ABOUT YOU

Treatment Purposes- Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. In addition, we may contact individuals through telephone, mail and email with appointment reminders and may utilize facsimile transmissions for specific authorizations and prescription refills through pharmacies. We may also disclose your PHI to other providers involved in your treatment.

Payment Purposes- We may use and disclose PHI to obtain payment for the treatment services provided. For example, we send PHI to Medicare, Medicaid, your health insurer, HMO, or other company or program that is to pay for your health care so they can determine if they should pay the claim. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

Health Care Operations- We may also disclose PHI to other health care providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, and peer review. We may share your PHI with third parties that perform various business activities such as an outside billing company, appointment reminder service or electronic practice management vendor provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.

Disclosure to Family, Close Friends and Other Caregivers- In an emergency situation, we may disclose PHI to those involved in a patient's care when the patient approves or, when the patient is not present or not able to approve, when such disclosure is deemed appropriate in the professional judgment of the practice or such as necessary. When the patient is not present, we determine whether the law requires the disclosure of the patient's PHI, and if so, disclose only the information directly relevant to the person's involvement with the patient's health care.

Disclosures Required by Law- As a behavioral health provider, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. However, we may also use or disclose PHI about you without your prior authorization, subject to certain requirements and as required by law. **Public Safety-** We may disclose your PHI if necessary, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If PHI is disclosed for this reason, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat. We may disclose PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect.

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

when required and as authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control. We may use and disclose your PHI in order to assist others in determining your eligibility for public benefit programs and to coordinate delivery of those programs. **Judicial and Administrative Proceedings-** We may use and disclose your PHI in judicial and administrative proceedings such as pursuant to a subpoena, court order, administrative order or similar process. Efforts may be made to contact you prior to a disclosure of your PHI to the party seeking the information. **Law Enforcement-** We may use or disclose PHI to law enforcement to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency. **Specialized Government Functions-** We may review requests from US military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Dept of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm. **Work-Related Injuries-** We may use or disclose PHI to an employer to evaluate work-related injuries. **Medical Emergencies-** We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm or to provide treatment in an emergency situation. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency. **Deceased Patients-** We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA. **Uses and Disclosures Required by Law – DO NOT APPLY TO PRACTICE.** We may disclose information as required by law for the following purposes although generally these do not apply to AIMH: marketing and research studies; fundraising; coroner or medical examiner and funeral directors for death certificate; disclosures to facilitate organ, eye and tissue donations.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

For any purpose other than the ones described above, we will only use or disclose your PHI when you give us your written authorization. For instance, we will obtain your written authorization before we send your PHI to your employer or health plan sponsor, for underwriting and related purposes for a life insurance company or to the attorney representing the other party in litigation in which you are involved. **Highly Confidential Information-** Federal and Illinois law requires special privacy protections for highly confidential information about you. Highly Confidential Information consists of PHI related to: psychotherapy notes; mental health and developmental disabilities services; alcohol and drug abuse services; HIV/AIDS testing, diagnosis or treatment; venereal disease(s); genetic testing; child abuse and neglect; domestic abuse of an adult with a disability; or sexual assault. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

YOUR RIGHTS REGARDING YOUR PHI

Right to Receive an Accounting of Disclosures- You have the right to request an accounting of disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or release made pursuant to your authorization. If you request an accounting more than once during a twelve (12) month period, we will charge you \$25. A request for disclosures must be made in writing to the Privacy Officer. **Right to Inspect and Copy Your PHI-** You have a right to inspect or get a copy of your medical record file and billing records maintained by us. In some circumstances, we may deny you access to a portion of your records. If you desire access to your records, submit your request in writing to the Privacy Officer. A reasonable fee, not to exceed limits allowed under Illinois law, will be charged for the copying and mailing. **Right to Amend Your Records-** You have the right to request that we amend PHI maintained in your medical record file or billing records. If you desire to amend your records, please submit your request in writing to the Privacy Officer. We are not required to agree with your request to amend. **Right to Request Restriction of Disclosures-** You may submit a request in writing to the Privacy Officer to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction. **Right to Receive Confidential Communications-** We accommodate all reasonable requests to keep communications confidential and to allow you to receive your PHI by alternative means of communication or at alternative locations. A request for confidential communications must be in writing, must specify an alternative address or other method of contact and must provide information about how payment will be handled. The request should be submitted to the Privacy Officer. We will determine the reasonableness based on the administrative difficulty of complying with the request. We will reject a request due to administrative difficulty if no independently verifiable method of communication (such as a mailing address or published telephone number) is provided for communications; or if the requestor has not provided information as to how payment will be handled. **Authorization-** We obtain written authorization from a patient or a patient's representative for the use or disclosure of PHI for reasons other than treatment, payment or health care operations. We will not, however, get an authorization for the use or disclosure of PHI specifically allowed under the Privacy Rule in the absence of an authorization. We do not condition treatment of a patient on the signing of an authorization, except disclosure necessary to determine payment of claim (excluding authorization for use or disclosure of psychotherapy notes); or provision of health care solely for the purpose of creating PHI for disclosure to a third party (pre-employment or life insurance exams). A specific written authorization is required to disclose or release mental health treatment notes, alcoholism treatment, drug abuse treatment or HIV/Acquired Immune Deficiency Syndrome (AIDS) information.

Right to Revoke Your Authorization- You have the right to revoke your written authorization, except to the extent that we have taken action in reliance upon it, by submitting your request in writing to the Privacy Officer. **Effective Date and Changes to this Notice-** This Notice is effective May 01, 2017. We reserve the right to revise this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new Notice. Any new Notice will be posted in the reception area of Frame of Mind Clinic LLC Breach **Notification-** If there is a breach of unsecured PHI concerning you, we may be required to notify you of the breach, including what happened and what you can do to protect yourself.

Right to a Copy of this Notice- You have the right to a copy of this Notice which may be obtained by contacting the Privacy Officer. **For Further Information or Complaints-** If you have questions, are concerned that your privacy rights have been violated, or disagree with a decision made about access to your PHI, you may contact our Privacy Officer who serves as the contact person for all issues related to the Privacy Rule. Complaints must be addressed to the attention of the Privacy Officer at Frame of Mind Clinic LLC at 6540 S Pecos Road Building A, Suite 103A Las Vegas Nevada 89120; Telephone No. (725) 726-8216. Written complaints may also be filed with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue SW, Washington, D.C. 20201. Complaints must name the practice, describe the acts or omissions that are the subject of the complaint, and must be filed within 180 days of the time you became aware or should have become aware of the violation. We will not retaliate or take any adverse action against you if you file a complaint.