Lynn Wagner, LPC
Mindlab
3 Dunwoody Park, Suite 103
Atlanta, GA 30338
770-715-5725
770-393-0522 fax

Dear Client

The following 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. Doing so will facilitate our ability to work in therapy/counseling together.

Thank you,
Lynn Wagner, LPC

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First Name _____ Last Name _____ MI _____

SSN _____ DOB _____ Age _____

Address _____ City _____ State _____ ZIP _____

Email Address _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Occupation _____

Emergency Contact Name _____ Relationship to Patient _____

Emergency Contact Phone _____ Cell Phone _____

Primary Care MD _____ Phone Number _____

Address _____ City _____ State _____ ZIP _____

Psychiatrist _____ Phone Number _____

Address _____ City _____ State _____ ZIP _____

Referred By _____

Marital Status:

- ❑ Single
- ❑ Married How many times? _____ How long? _____
- ❑ Divorced How many times? _____ How long? _____
- ❑ Widow/Widower How many times? _____ How long? _____
- ❑ Domestic Partnership or Cohabitation How many times? _____ How long? _____

Living Situation: Own Rent

- ❑ House
- ❑ Condominium
- ❑ Apartment
- ❑ Other _____

Briefly 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: _____

_____

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Please list all medications (including dosages) that you are currently taking:

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 List

Do you have pain management issues? Yes No

Please List

Do you have a history of developmental issues? Yes No

Please List

Do you have any medical problems? Yes No

Please List

Have you ever been treated for drug or alcohol abuse or other addictions (food, gambling, sex, internet)? Yes No

Circle any of the following you have used in the past 30 days: tobacco, alcohol, marijuana, tranquilizers, sleeping pills, pain killers, heroin, cocaine/crack, amphetamines/speed, Benzodiazepines, Methadone, LSD, Ecstasy, inhalants

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 List

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

Please List

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

Please List

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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 List _____

Do you have any legal problems? Yes No

Please List _____

Have you ever been a victim of abuse? Yes No

- ❑ physical
- ❑ emotional
- ❑ sexual

Please list all of your children, including their age: _____

_____

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 continue on the back of this sheet 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 _____

Please explain any recent changes have you experienced in the following:

- ❑ Mood _____
- ❑ Sleep _____
- ❑ Concentration _____
- ❑ Energy _____
- ❑ Interest in things that you normally enjoy _____
- ❑ Appetite _____
- ❑ Libido _____
- ❑ Feelings of guilt _____

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- ❑ Thoughts of hurting yourself/suicide_____
  - o If you have these thoughts now or have ever had them in the past, please indicate dates and circumstances_____
  - o Has anyone close to you ever committed suicide or talked about hurting himself or herself?_____
- ❑ Thoughts of hurting someone else_____

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Primary Insurance Information and Benefit Verification Worksheet and Consent to Treatment

Patient Name_____

DOB of Patient _____ SS# of Patient_____

Insurance Provider_____ Effective Date_____

Policy Number_____ Group Number_____

Name of *Primary* Insured (if different from patient)_____

Employer of *Primary* Insured _____

DOB of *Primary* Insured_____ SS# of *Primary* Insured_____

Phone Number for Mental Health Services_____

Name of Insurance Rep with whom you spoke and date you spoke with them_____

Are Authorizations required? Yes No

Number of sessions authorized_____

Authorization Number(s)_____

CPT Code(s)_____

Start Date_____ End Date_____

Copay_____ Deductible_____

Has the deductible been met for this year? Yes No

Maximum Visits per Year_____

What is the specific address for Mental Health Claims (this address is usually different from the general medical claims address on your insurance card)

_____

_____

_____

Lynn Wagner, LPC is required by law to collect all co-pays at the time of service. There will be a $25.00 service charge for any unpaid/returned checks. Please note: we do not file secondary insurance unless required to do so by federal law.

If you have insurance that requires preauthorization, you must notify your clinician of any changes in your insurance coverage and benefits before each visit. It is your responsibility to ensure that your visits are fully authorized by your insurance company. By law, we cannot bill your insurance for missed appointments. You are responsible for the full payment of all appointments not cancelled with at least 24-hour notice.

I hereby authorize all information necessary for the purpose of authorizing and processing my claims to be released to my insurance company. I understand this information may include diagnoses, dates of service, charges, symptoms, and treatment recommendations. I understand that I am fully responsible for my bill and will assume any charges not paid by my insurance company. I understand that I will be charged $100.00 for any appointments not kept unless at least a FULL 24-HOUR notice (a 72-hour notice is required if cancellation is for a Monday appointment) is given to the clinician.

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

_____ _____

Psychotherapist-Client Services Agreement

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(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 new federal law that provides new privacy protections and new 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
Psychotherapy 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.

Psychotherapy 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. Sessions begin on the hour and last 45 to 50 minutes. The last five minutes will be used to make any payments or co-payments and to schedule our next session. In order to make the most of our time together, you may wish to fill our your check prior to the session. I strive to be punctual and I expect you to respect that your session ends after 45 to 50 minutes. If a patient has a consistently difficult time leaving on time, such behavior will necessarily and appropriately become a subject in treatment. **Once an appointment is scheduled, you will be expected to pay a $100.00 fee unless you provide at least 24 hours advance notice of cancellation** . Please note that insurance will not reimburse for cancelled or missed sessions.

Professional Fees
My per-session fee is $100.00. 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 5 minutes, and the time spent performing any other service you may request of me that is not specifically covered by insurance. In general, 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, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if another party calls me. This payment must be paid in advance of my participation. My fee for participation at any such proceedings is $150.00 per hour with a four-hour minimum ($600.00). Travel time will be billed in addition to actual court time.

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Contacting Me
Due to my work schedule, I am often not immediately available by telephone or in person. I am usually in my office from 9:30 AM to 6:00 PM but my calls will go to confidential voicemail because I am with clients most, if not all of the day. My voicemail system is programmed to page me when I receive a message. I will make every effort to return your call on the same day you made it, or at least within 24 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 call is an emergency, please call 911, your family physician, or 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.

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).
- 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 black 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 PHI 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

Notice. If I deny your request for access to your records, you have the right of review (except for information provided to me confidentially by others) that I will discuss with you upon your request.

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.

Billing and Payments
You are expected to pay for each session (including any co-pays) at the time it is held, unless we agree otherwise or unless your insurance coverage requires another arrangement. 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.

Insurance Reimbursement
In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it may or may not provide at least some coverage for mental health treatment. I will fill out claim forms and file them with your insurance company. It is important that you find out exactly what mental health services are covered by your insurance.

You should read the section in your insurance coverage booklet that describes mental health services carefully. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can based on my experience and will be happy to help you to understand to information you receive from your insurance company. It may take a collaborative effort to make the most of your insurance coverage.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Heath Care" plans such as HMOs and PPOs often require advanced treatment authorization in order to activate reimbursement. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning (i.e.; crisis counseling). It may be necessary to seek approval for additional therapy sessions after a certain initial number of sessions are completed. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that your contract with your health insurance company requires that I provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or

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a copy of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information required for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Although all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. (Because of this, some of my patients elect to pay out-of-pocket for treatment instead of claiming it on insurance. The choice is entirely up to you.) I will provide you with a copy of any report submitted to your insurance upon request. By signing this Agreement, you agree that I can provide requested information to your insurance carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your counseling. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, or when your coverage ends.

Please note that I am not equipped to accept credit or debit cards at this time.

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. YOUR SIGNATURE BELOW ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE GEORGIA HIPAA PRIVACY NOTICE FORM DESCRIBED ABOVE.

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Patient Signature	Date
Patient or Guardian Signature	Date

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CONSENT TO RELEASE CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIAN

This form is required by your insurance company to ensure coordination of care. Information will not be released without your written consent. This information may include diagnosis, treatment plan, progress, and medication, if necessary. You may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire one (1) year from the date of signature, unless another date is specified.

I hereby authorize Lynn Wagner, LPC to release information concerning my psychological evaluation, consultation, diagnosis, personal history, treatment, and recommendations/referrals to:

_____
Name of Primary Care Physician

At the following address, phone, and fax number:

Street Address_____

City_____State_____Zip_____

Phone_____Fax_____

I hereby authorize_____
Name of Primary Care Physician

to release information concerning my psychological evaluation, consultation, diagnosis, personal history, treatment and recommendations/referrals to Lynn Wagner, MA, LPC at:

Lynn Wagner, LPC
Mindlab
3 Dunwoody Park, Suite 103
Atlanta, GA 30338
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I understand that this release is voluntary and may be rescinded in writing at any time, not withstanding actions taken and information released during the time this document was in effect, and that in any event this consent shall expire one (1) year from the date of signature, unless another date is specified. I agree that Lynn Wagner, MA, LPC shall not be held liable in any manner for furnishing or having furnished such information. I have read and understand the above information and give my consent:

Please check only one box:

- ❑ To release any applicable information to my primary care physician
- ❑ To release only medication information to my primary care physician
- ❑ I do not give my consent to release any information to my primary care physician

Patient's Printed Name:_____

Patient Signature:_____

Date:_____

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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 disclosed information in order to provide protection against such danger for you or the intended victim.

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- *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.

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.

Lynn Wagner, MA, LPC 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.

Patient Signature_____ Date_____

Printed Name_____

Lynn Wagner, LPC
Mindlab
3 Dunwoody Park, Suite 103
Atlanta, GA 30338
770-715-5725
770-393-0522 fax

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.

_____ _____

Patient Signature Date

_____

Please Print Patient Name