Jennifer Bailey, Psy.D.
1115 Upper Hembree Road, Suite B, Roswell, GA 30076
VOICE: 770 685-6412, FAX: 770 475-1171

Child/Adolescent Client Information Form

This Form is Completely Confidential

Today's date: _____

Child's name: _____
Last First Middle Initial

Date of Birth:_____ **Gender: IMale IFemale**

Home Street Address: _____

City:_____**State:**_____**Zip: Mother's Name** ____

_____

Address (if Different): _____

Home Phone:_____Work Phone: _____

Cell Phone:_____Email: _____

Father's Name _____

Address (if Different): _____

Home Phone:_____Work Phone: _____

Cell Phone:_____Email:_____

Who has legal custody? _____

Person(s) to notify in case of any emergency:

_____ _____

(name) (phone) (name) (phone)

We will contact this person only if we believe it is a life or death emergency. Please sign here to indicate that we have your permission: *x*_____

Referred by: _____

May I have your permission to thank this person for the referral? **I Yes I No**

If referred by another clinician, may we communicate with one another? **I Yes I No**

Please briefly describe why you are seeking therapy for your child: _____

_____

_____

_____

_____

What are your goals for your child's therapy? _____

_____

_____

_____

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The following information will help guide your treatment.

Please include as much information as you are comfortable disclosing.
If you need more room, please use the back of this page.

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses your child has now or has had in the past:

Current Medications (if you need more room, please write on the back of this page)**:**

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Has your child ever been hospitalized? (Approximate dates and reasons)

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional in the past?
I Yes I No (Please list name, approximate date, and reason):

RELATIONSHIPS, SOCIAL SUPPORT:

Does your child have friends? How much time does he/she spend with friends outside of school?

Do you have any concerns about your child's social skills? If so, please list any concerns you have:

Does your child have problems at school? If so, please discuss briefly

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List the names and ages of other children living with you:

Describe any problems any of your other children are having:

Do you have any extended family close by? Do they spend time with your child?

It is very important that parents care for themselves as well as their children. What do you do to cope with stress?

What do you think are your strengths as a parent:

What are some areas where you think your parenting can improve?

Many families identify different parts of their day as more or less stressful.
Please rank each time of day from 1= *Very Stressful* to 5= *Pleasant*.

	Very Stressful				Pleasant
Waking/getting ready for school	1	2	3	4	5
Going to school	1	2	3	4	5
Homework	1	2	3	4	5
Dinnertime	1	2	3	4	5
Evening routine	1	2	3	4	5
Bedtime	1	2	3	4	5
Weekends/Vacations	1	2	3	4	5

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PLEASE **CHECK** ALL THAT APPLY & **CIRCLE** YOUR CHILD'S MAIN DIFFICULTIES:

Difficulty With:	Now	Past	Difficulty With:	Now	Past	Difficulty With:	Now	Past
Anxiety			People in General			Nightmares		
Depression			Siblings			Nausea		
Mood Changes			School			Abdominal Distress		
Anger or Temper			Teachers			Fainting		
Panic			Friend(s)			Dizziness		
Fears			School Refusal			Constipation		
Irritability			Easily Frustrated			Wets bed		
Concentration			Transitions			Soiling		
Headaches			Oppositional			Picky Eater		
Loss of Memory			Aggression			Sensory Problems		
Excessive Worry			Argumentative			Allergies		
Communicating with Others			Meltdowns/Temper Tantrums			Often Makes Careless Mistakes		
Trusting Others			Cries Frequently			Fidgets Frequently		
Drugs			Threats to Hurt Someone Else			Speaks Without Thinking		
Alcohol			Hurting Self			Impulsive		
Caffeine			Thoughts of Suicide			Hyperactive		
Frequent Vomiting			Sleeping Too Much			Completing Tasks		
Eating Problems			Sleeping Too Little			Paying Attention		
Severe Weight Gain			Getting to Sleep			Easily Distracted by Noises		
Severe Weight Loss			Waking Too Early			Other (please list)		

FAMILY HISTORY OF (Check all that apply):

☐ Drug/Alcohol Problems ☐ Physical Abuse ☐Depression

☐ Legal Trouble ☐ Sexual Abuse ☐ Anxiety

☐ Domestic Violence ☐ Hyperactivity ☐ Psychiatric Hospitalization

☐ Suicide ☐ Learning Disabilities ☐ "Nervous Breakdown"

Any additional information you would like to include:

_____

_____

_____

_____

_____

Thank You!

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INFORMATION, AUTHORIZATION,& CONSENT to TREATMENT of YOUR CHILD

I am very pleased that you have selected me to be your child's psychotherapist, and I am sincerely looking forward to assisting both of you through this process of discovery.

This document will inform you about my professional services and business policies. Please know that our relationship is a collaborative one, and I always welcome any questions, comments, or suggestions regarding your child's course of therapy. In many cases I schedule separate parenting sessions during the course of our work.

It will be my job to help show your child the way to better self control, better relationships with family and friends, and better ways to resolve various problems. Some children need only a few sessions to achieve their goals, whereas others may require a much longer time.

It is my role to facilitate learning, change, and ultimately growth. I am very committed to helping your child discover the best ways to produce the maximum benefit. Of course, it is important that not only your child but also you, the parent, take on an active role. This means working on the things we talk about both during and between sessions. Like most other things in life, the more time and effort you and your child are willing to invest, the greater the return.

FEE SCHEDULE

Initial Diagnostic Interview – 75 minutes	$250
Individual/Family Psychotherapy 45-50 min	$175
In Home Psychotherapy per hour	$225
Court Preparation/Testimony	$1500 half day/$3000 full day
Telephone Calls exceeding 10 minutes	$3 per minute

Doing psychotherapy by telephone is not ideal, and needing to talk to me between sessions may indicate the need for extra support. If this is the case, you and I will need to explore adding sessions or developing other resources you have available to help your child.

Payment in full is due at each session. Cash, personal checks, Visa, MasterCard, or American Express are acceptable for payment, and I will provide you with a receipt of payment. The receipt of payment may also be used as a statement for insurance if applicable to your child. Please note that there is a $25 fee for any returned checks.

Insurance Reimbursement

Most insurance companies provide some coverage for mental health treatment. I will provide you with an itemized payment receipt that contains all of the information that most insurance companies require. Some insurance companies may require you to pre-certify treatment. It is your responsibility to contact your insurance company and discuss this with them.

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It is important to note that you (and not your insurance company) are responsible for full payment of fees in a timely manner.

Most insurance companies will require me to provide a clinical diagnosis. Some insurance companies may require a treatment plan or summary. This information becomes part of the insurance company files. In some cases, *your insurance company* may send the information to a national medical information data bank. This raises concerns about privacy and confidentiality for many people. To avoid the possibility of insurance companies obtaining any information about your child's mental health care, you always have the right to pay for services yourself. Many parents (or guardians) have chosen this option for their children.

Insurance companies have many rules and requirements specific to certain plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. I will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

Confidentiality & Records

Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in my office.

In general, the law protects the confidentiality and privacy of all communications between a patient and a psychologist and I can only release information about our work to others with your written permission. However, there are a few exceptions:

1. If the patient is under 18 years of age, the law may give their parents or legal guardians the right to access their records. It is my policy that the parents or legal guardians verbally agree that they will give up this right so that patients under 18 years old may have privacy in their sessions. If they agree, I will provide them only with general information on how the child's treatment is proceeding. An exception to this would be if I believe that the child is in imminent danger of hurting themselves or someone else, in which case I will let the parents or legal guardians know of my concerns.

2. If I believe that a child is being abused, I am required to file a report with the appropriate state agency.

3. If I believe that a patient is threatening serious bodily harm to another person, I am required to take protective actions. This may include notifying the personal victim or notifying the police. If a patient threatens to harm himself/herself I may be required to seek hospitalization for the patient, or to contact family members or others who can help provide protection.

These circumstances occur *very rarely.* Should such a situation arise, I will make every effort to discuss it with you prior to taking any action.

Cancellation Policy

In the event that you are unable to keep an appointment, you must notify me at least 24 hours in advance. If your appointment is on a Monday, please notify me by noon on the Friday before our appointment if you need to cancel. If such advance notice is not received, you will be financially

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responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

In Case of an Emergency

My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. You may leave me a confidential voicemail message 24 hours a day. I check for messages on a regular basis during business hours. If you are calling after 5:00 P.M., or on weekends or holidays, it will be the next business day before I can return your call.

- If you need to reach me after hours, you can call my pager number, (404) 242-4166 and I will return your call as soon as I can.
- If your child is involved in a medical emergency or a possibility of injury or death, call 911 immediately.
- If your child has a mental health emergency, do not wait for me to return your call. Instead, *immediately* do one or more of the following:
  - Call Ridgeview Institute at 770.434.4567 or Peachford Hospital at 770.454.5589.
  - Call 911.
  - Go to your nearest emergency room.

Please email me only for appointment changes and other non-urgent, business communications. Email is not secure and I cannot guarantee either confidentiality or a prompt response. Do not use email for emergencies or for clinical use such as describing problems, feelings, urges, etc.

Statement Regarding Ethics, Client Welfare & Safety

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association. If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please let me know immediately. If we are unable to resolve your concern, I will provide you with information to contact the Georgia professional licensing board that governs my profession.

I am sincerely looking forward to working with your child. If you have any questions about any part of this document, please ask.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with me as your child's therapist, and you are authorizing me to begin treatment with your child.

Patient Name (pleaseprint) _____ **Date** _____

Parent or Guardian's Name (please print) _____ **Date** _____

Parent or Guardian's Signature _____

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

Dr. Jennifer Bailey _____ **Date** _____

Jennifer Bailey, Psy.D.
1115 Upper Hembree Road, Suite B, Roswell, GA 30076
(770) 685-6412

Your signature below indicates that you have been given the opportunity to review the Notice "Health Insurance Portability and Accountability Act (HIPAA) NOTICE OF PRIVACY PRACTICES" regarding your protected health information (PHI).
You may request a copy of this Notice at any time.

_____
Client Name (please print)

_____ _____
Client Signature **Date**

If Applicable:

_____
Parent/Legal Guardian Name (please print)

_____ _____
Parent/Legal Guardian Signature **Date**

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CONSENT & AUTHORIZATION TO RELEASE INFORMATION

If there are other parties that may assist in your therapy, and you believe it would be helpful for me to contact them regarding your treatment, please read carefully and complete this document.

The following is an authorization for the stated parties to consult with one another regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you as the client. Please provide the necessary information and your signature with today's date as indicated below.

Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

I, *(please print)*_____, (client or legal guardian) hereby authorize Jennifer Bailey, Psy.D. (therapist) and the following party or parties to discuss_____'s (client's)mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to, therapist's diagnosis:

(1) _____

(2) _____

(3) _____

Please indicate your preference regarding the information to be shared:

____ The parties stated above may discuss my medical and/or mental health information without limitations.

____ I would prefer to limit the information shared between the parties stated above. The limitations I would like to make are as follows: _____

_____

_____

_____

Additionally, the above named parties, therapist and person(s) or entity (entities) designated under (1), (2) or (3), agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless the therapist stated above has taken action in reliance upon it.
Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by Jennifer Bailey, Psy.D. at 1115 Upper Hembree Road, Suite B, Roswell, GA 30076 to be effective.

Client's Signature:_____Date: _____

Parent's/Legal Guardian's Signature:_____Date: _____

Dr. Lisa Cheyette & Associates

Jennifer Bailey, Psy.D.

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Technology Statement

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to me that I maintain your confidentiality, respect your boundaries, and ascertain that your relationship with me remains therapeutic and professional. Therefore, I've developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure and confidential. However, I realize that most people have and utilize a cell phone. may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with me.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to text and/or email because it is a quick way to convey information. If you choose to utilize texting or email, please discuss this with me. **However, please know that it is my policy to utilize these means of communication strictly for brief topics such as appointment confirmations.** Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. **You also need to know that I am required to keep a copy of all emails and texts as part of your clinical record.**

Facebook, LinkedIn, Instagram, Pinterest, Etc.: It is my policy not to accept requests from any current or former client on social networking sites such as Facebook, LinkedIn, Instagram, Pinterest, etc. because it may compromise your confidentiality.

Google, etc.: It is my policy not to search for my clients on Google or any other search engine. I respect your privacy and make it a policy to allow you to share information about yourself with me as you feel appropriate. If there is content on the Internet that you would like to share with me for therapeutic reasons, please print this material out and bring it to your session.

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Please feel free to ask questions, and know that I am open to any feelings or thoughts you have about these and other modalities of communication.

Our signatures below indicates that you have read and understood my technology policy, that I have discussed this form with you and have answered any questions you have regarding this information.

_____ _____

Patient Signature Date

_____ _____

Dr. Jennifer Bailey Date

Jennifer Bailey, Psy.D.
1115 Upper Hembree Road, Suite B, Roswell,GA 30076
Voice: 770 685-6412, Fax: 770475-1171

Health Insurance Portability and Accountability Act (HIPAA)
NOTICE OF PRIVACY PRACTICES

Effective01/24/2011

I. COMMITMENT TO YOUR PRIVACY: Jennifer Bailey, Psy. D. is dedicated to maintaining the privacy of your protected health information (PHI). PHI is information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. This Notice of Privacy Practices ("Notice") is required by law to provide you with the legal duties and the privacy practices that Jennifer Bailey, Psy.D. maintains concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

II. LEGAL DUTY TO SAFEGUARD YOUR PHI: By federal and state law, Jennifer Bailey is required to ensure that your PHI is kept private. This Notice explains when, why, and how Jennifer Bailey, Psy.D. would use and/or disclose your PHI. Use of PHI means when Jennifer Bailey, Psy.D. shares, applies, utilizes, examines, or analyzes information within its practice; PHI is disclosed when Jennifer Bailey, Psy.D., releases, transfers, gives, or otherwise reveals it to a third party outside of the Institute. With some exceptions, Jennifer Bailey, Psy.D. may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, Jennifer Bailey, Psy.D. is always legally required to follow the privacy practices described in this Notice.

III. CHANGES TO THIS NOTICE: The terms of this notice apply to all records containing your PHI that are created or retained by Jennifer Bailey, Psy.D. Please note that Jennifer Bailey, Psy.D. reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that Jennifer Bailey, Psy.D. has created or maintained in the past and for any of your records that Jennifer Bailey, Psy.D. may create or maintain in the future. Jennifer Bailey, Psy.D. will have a copy of the current Notice in the office in a visible location at all times, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of Jennifer Bailey, Psy.D.'s Notice of Privacy Practices.

IV. HOW Jennifer Bailey, Psy.D. MAY USE AND DISCLOSE YOUR PHI: Jennifer Bailey, Psy.D. will not use or disclose your PHI without your written authorization, except as described in this Notice or as described in the "Information, Authorization and Consent to Treatment" document. Below you will find the different categories of possible uses and disclosures with some examples.

1. For Treatment: Jennifer Bailey, Psy.D. may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If you are also seeing a psychiatrist for medication management, Jennifer Bailey, Psy.D. may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, Jennifer Bailey, Psy.D. will always ask for your authorization in writing prior to any such consultation.

2. For Health Care Operations: Jennifer Bailey, Psy.D. may disclose your PHI to facilitate the efficient and correct operation of its practice. Example: Quality control - Jennifer Bailey, Psy.D. may provide your PHI to its office personnel, accountants, practice consultants, attorneys and others to make sure that Jennifer Bailey, Psy.D. are in compliance with applicable practices and laws. It is Jennifer Bailey Psy.D.'s practice to conceal all client names in such an event and maintain confidentiality. However, there is still a possibility that your PHI may be audited for such purposes.

3. To Obtain Payment for Treatment: Jennifer Bailey, Psy.D. May use and disclose your PHI to bill and collect payment for the treatment and services Jennifer Bailey, Psy.D. provided you. Example: Jennifer Bailey, Psy.D. might send your PHI to your insurance company or managed health care plan, in order to get payment for the health care services that have been provided to you. Jennifer Bailey, Psy.D. could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for Jennifer Bailey's office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, Jennifer Bailey, Psy.D. will always do her best to reconcile this with you first prior to involving any outside agency.

4. Employees and Business Associates: There may be instances where services are provided to Jennifer Bailey, Psy.D. by an employee or through contracts with third-party "business associates." Whenever an employee or business associate arrangement involves the use or disclosure of your PHI, Jennifer Bailey, Psy.D. will have a written contract that requires the employee or business associate to maintain the same high standards of safeguarding your privacy that is required of Jennifer Bailey, Psy.D

Note: Georgia and Federal law provides additional protection for certain types of health information, including **alcohol or drug abuse, mental health and AIDS/HIV,** and may limit whether and how Jennifer Bailey, Psy.D. may disclose information about you to others.

V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES – Jennifer Bailey, Psy.D. **may use and/or disclose your PHI without your consent or authorization for the following reasons:**

1. **Law Enforcement:** Subject to certain conditions, Jennifer Bailey, Psy.D. may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: Jennifer Bailey, Psy.D. may make a disclosure to the appropriate officials when a law requires Jennifer Bailey, Psy.D. to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **Lawsuits and Disputes:** Jennifer Bailey, Psy.D. may disclose information about you to respond to a court or administrative order or a search warrant. Jennifer Bailey, Psy.D. may also disclose information 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. Jennifer Bailey, Psy.D. will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the information requested.
3. **Public Health Risks:** Jennifer Bailey, Psy.D. may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.
4. **Food and Drug Administration (FDA):** Jennifer Bailey, Psy.D. may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
5. **Serious Threat to Health or Safety:** Jennifer Bailey, Psy.D. may disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if Jennifer Bailey, Psy.D. determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, Jennifer Bailey, Psy.D. may provide PHI to law enforcement personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.
6. **Minors:** If you are a minor (under 18 years of age), Jennifer Bailey, Psy.D. may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.
7. **Abuse and Neglect:** Jennifer Bailey, Psy.D. may disclose PHI if mandated by Georgia child, elder, or dependent adult abuse and neglect reporting laws. Example: If Jennifer Bailey, Psy.D. has a reasonable suspicion of child abuse or neglect, Jennifer Bailey, Psy.D. will report this to the Georgia Department of Child and Family Services.
8. **Coroners, Medical Examiners, and Funeral Directors:** Jennifer Bailey, Psy.D. may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death or other duties as authorized by law. Jennifer Bailey, Psy.D. may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.
9. **Communications with Family, Friends, or Others:** Jennifer Bailey, Psy.D. may release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related decisions for you), or any other person you identify, relevant to that person's involvement in your care or payment related to your care. In addition, Jennifer Bailey, Psy.D. may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.
10. **Military and Veterans:** If you are a member of the armed forces, Jennifer Bailey, Psy.D. may release PHI about you as required by military command authorities. Jennifer Bailey, Psy.D. may also release PHI about foreign military personnel to the appropriate military authority.

11. **National Security, Protective Services for the President, and Intelligence Activities:** Jennifer Bailey, Psy.D. may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law.
12. **Correctional Institutions:** If you are or become an inmate of a correctional institution, Jennifer Bailey, Psy.D. may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others
13. **For Research Purposes:** In certain limited circumstances, Jennifer Bailey, Psy.D. may use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified, directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.
14. **For Workers' Compensation Purposes:**
    Jennifer Bailey, Psy.D. may provide PHI in order to comply with Workers' Compensation or similar programs established by law.
15. **Appointment Reminders:** Jennifer Bailey, Psy.D. is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that you may need or that may be of interest to you.
16. **Health Oversight Activities:** Jennifer Bailey, Psy.D. may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess Jennifer Bailey's compliance with HIPAA regulations.
17. **If Disclosure is Otherwise Specifically Required by Law.**

VI. Other Uses and Disclosures Require Your Prior Written Authorization: In any other situation not covered by this notice, Jennifer Bailey, Psy.D. will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying Jennifer Bailey, Psy.D. in writing of your decision. You understand that Jennifer Bailey, Psy.D. is unable to take back any disclosures it has already made with your permission, Jennifer Bailey, Psy.D. will continue to comply with laws that require certain disclosures, and Jennifer Bailey, Psy.D. is required to retain records of the care that its therapists have provided to you.

VII. RIGHTS YOU HAVE REGARDING YOUR PHI:

1. The Right to See and Get Copies of Your PHI: In general, you have the right to see your PHI that is in Jennifer Bailey's possession, or to get copies of it; however, you must request it in writing. If Jennifer Bailey, Psy.D. does not have your PHI, but knows who does, you will be advised how you can get it. You will receive a response from Jennifer Bailey, Psy.D. within 30 days of receiving your written request. Under certain circumstances, Jennifer Bailey, Psy.D. may feel it must deny your request, but if it does, Jennifer Bailey, Psy.D. will give you, in writing, the reasons for the denial. Jennifer Bailey, Psy.D. will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged not more than $.25 per page and the fees associated with supplies and postage. Jennifer Bailey, Psy.D. 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.

2. The Right to Request Limits on Uses and Disclosures of Your PHI: You have the right to ask that Jennifer Bailey, Psy.D. limit how it uses and discloses your PHI. While Jennifer Bailey, Psy.D. will consider your request, it is not legally bound to agree. If Jennifer Bailey, Psy.D. does agree to your request, it 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 Jennifer Bailey, Psy.D. is legally required or permitted to make.

3. The Right to Choose How Jennifer Bailey, Psy.D. **Sends 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). Jennifer Bailey, Psy.D. is obliged to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience.

4. The Right to Get a List of the Disclosures. You are entitled to a list of disclosures of your PHI that Jennifer Bailey, Psy.D. has made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, or to corrections or law enforcement personnel. The request must be in writing and state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003.

Jennifer Bailey, Psy.D. will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a description of the information disclosed, and the reason for the disclosure. Jennifer Bailey, Psy.D. will provide the list to you at no cost, unless you make more than one request in the same year, in which case it will charge you a reasonable sum based on a set fee for each additional request.

5. 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 Jennifer Bailey, Psy.D. 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 Jennifer Bailey's receipt of your request. Jennifer Bailey, Psy.D. may deny your request, in writing, if she finds that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, (c) not part of its records, or (d) written by someone other than Jennifer Bailey, Psy.D. 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 Jennifer Bailey's denial will be attached to any future disclosures of your PHI. If Jennifer Bailey, Psy.D. approves your request, it will make the change(s) to your PHI. Additionally, Jennifer Bailey, Psy.D. will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

6. 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.

7. Submit all Written Requests: Submit to "Jennifer Bailey, Psy.D." at the address listed on top of page one of this document.

VIII. COMPLAINTS: If you are concerned your privacy rights may have been violated, or if you object to a decision Jennifer Bailey, Psy.D. made about access to your PHI, you are entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services Office of Civil Rights. Jennifer Bailey, Psy.D. will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Please discuss any questions or concerns with Dr. Bailey. Your signature below indicates that you Acknowledge receipt of this Notice:

_____
Client Name (please print)

_____ _____
Client Signature **Date**

If Applicable:

_____
Parent/Legal Guardian Name (please print)

_____ _____
Parent/Legal Guardian Signature **Date**

Date of Last Revision: 03/03/2016