PNS | Pacific Neuropsychiatric Specialists

PATIENT REGISTRATION

Please Select Your Treatment Office Below:

- ☐ Costa Mesa: 3151 Airway Ave., G-1, Costa Mesa, CA, 92626
- ☐ Orange: 705 West La Veta Ave., Suite 111, Orange, CA 92868
- ☐ Mission Viejo: 26024 Acero, Mission Viejo, CA 92691
- ☐ Huntington Beach: 19671 Beach Blvd Suite 215, Huntington Beach, CA 92648
- ☐ Orange: 1310 West Stewart Dr, Suite 306, Orange, CA 92868
- ☐ Santa Ana: 999 North Tustin Ave., Suite 216, Santa Ana, CA 92705

Name:	Date of Birth:	Age:
Address:	City:	State & Zip:
Email Address:	Occupation:	
Cell Phone Number:	Secondary Phone Number:	
Marital Status ☐ Single ☐ Married ☐ Divorced	Gender ☐ Female ☐ Male ☐ Undifferentiated	DL Number:
Name of Primary Care MD/NP/PA: _____ City: _____ Phone Number: _____		Consent to Collaborate? ☐ Yes ☐ No
Name of Therapist: _____ City: _____ Phone Number: _____		Consent to Collaborate? ☐ Yes ☐ No

Policy Holder and DOB (If other than self): _____

I have provided my primary insurance card: ☐ Yes ☐ No ☐ N/A I have provided my secondary insurance card: ☐ Yes ☐ No ☐ N/A

How did you hear about us?

☐ Pnsoc.com ☐ Internet Search ☐ Hospital ☐ Insurance ☐ Google ☐ School ☐ Therapist

☐ Friend/Family:_____ ☐ Other:_____

Patient Name: _____ Signature: _____ Date: _____

PATIENT PORTAL REGISTRATION

Pacific Neuropsychiatric Specialists is excited to offer a new feature-a patient portal! The patient portal is a convenient, secure online tool available 24/7!

SIGN UP FOR THE PATIENT PORTAL TODAY!

Simply fill out your name and email information below, and you will receive a link in the email you listed below to complete registration for the Patient Portal!

Patient Name: _____ Signature: _____ Email: _____

Date of Birth: _____ Date: _____

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EMERGENCY CONTACT

IN THE EVENT OF A LIFE-THREATENING EMERGENCY ONLY

Your emergency contact will not have access to your medical records or be able to schedule appointments on your behalf

Patient Name: _____ Date of Birth: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

Patient Name: _____ Date of Birth: _____

Name/Organization: _____ Relationship: _____

Phone Number: _____ Fax Number: _____

CHECK ONE or BOTH: ☐ OBTAIN information ☐ RELEASE information

Name/Organization: _____ Relationship: _____

Phone Number: _____ Fax Number: _____

CHECK ONE or BOTH: ☐ OBTAIN information ☐ RELEASE information

Rights and Restrictions: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. I may inspect or obtain a copy of this authorization to be used and/or disclosed under this authorization in accordance with organizational policy. Photocopy/Fax may be used as an original. I understand I have the right to revoke this authorization in writing at any time or change what information is to be released. My revocation will be effective upon receipt but will not be effective to the extent that this organization has taken action in reliance upon this authorization. Under California law, however, a recipient of medical information, whether disclosed pursuant to an authorization or to the discretionary provisions of California Civil Code #56.1O(x), may not further disclose that medical information except in accordance with a new authorization or as specifically required or permitted by law.

I,_____ (name of patient or guardian), hereby authorize Pacific Neuropsychiatric Specialists, Inc. to disclose information and records obtained in the course of my diagnosis and treatment and to receive information about my diagnosis and treatment for the following purposes: to obtain previous medical/psychiatric history, assist in diagnosis and treatment, and coordinate care on an ongoing basis with my other providers.

Patient Name: _____ Signature: _____ Date: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF PHI

Transcranial Magnetic Stimulation and Clinical Research: Pacific Neuropsychiatric Specialists offers transcranial magnetic stimulation by Neurostar, a drug-free treatment option for patients with depression, as well as clinical research trials. PNS Clinical Research, LLC, has assisted in the development of new and novel medical compounds in clinical trials that may not be available to our patients on the open market. If you qualify for the study, PNS Clinical Research, LLC, will provide clinical trials and investigational medication to you or your loved ones at no cost. Most of the commercially available mental health medications were available to our patients prior to official FDA approval. If you or a loved one are interested in these novel medication trials, please sign the information release form below.

Laboratory Diagnostics: Our medical staff may recommend that certain lab tests/blood work be ordered as part of your treatment plan to aid in diagnosis and rule out medical causes of symptoms. Certain medications necessitate routine and periodic blood tests. Pacific Neuropsychiatric Specialists collaborates with Families Together of Orange County to provide you with high-quality, comprehensive care.

By signing this form, I authorize Pacific Neuropsychiatric Specialists to discuss my treatment options with PNS Clinical Research, LLC, Neurostar, and Families Together of Orange County, and I give my consent for their staff to contact me for treatment options that may include medication, laboratory work, office consultations, and diagnostic imaging if I qualify.

Patient Name: _____ Signature: _____ Date: _____

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PATIENT HEALTH HISTORY QUESTIONNAIRE

Current symptoms/reason for seeking treatment:

Height:	Weight:	Hours of sleep per night:	Hours of exercise per week:

Please list any current or past medical conditions/surgeries:

Date of last physical and labs:	Allergies:

List **all** current prescribed or over-the-counter medications, vitamins/herbs, and previous psychiatric medications with doses:

Current Prescription Medications	Current Vitamins/Supplements/OTCs	Past Psychiatric Medications

Check the box if you have a history of any of the following:

- ☐ Anxiety
- ☐ Depression
- ☐ Eating Disorder
- ☐ Excessive Energy
- ☐ Hallucinations
- ☐ Impulsivity
- ☐ Racing Thoughts
- ☐ Self-Harm
- ☐ Sleep Disturbances
- ☐ Suicide Attempts
- ☐ Childhood history of mental health symptoms/academic difficulties
- ☐ Psychiatric Hospitalization (s)? (If yes, list number): _____

Past substance use/admittance to treatment centers? ☐ **Yes** ☐ **No**

Sober Date (if applicable/in recovery): _____

Check the box and list the quantity or times per day if using any of the following substances:

- ☐ Alcohol _____ per day
- ☐ Amphetamines _____ per day
- ☐ Cocaine _____ per day
- ☐ Cigarettes _____ per day
- ☐ Marijuana _____ per day
- ☐ Opiates _____ per day
- ☐ PCP _____ per day
- ☐ Interested in smoking cessation?
- ☐ Medical Marijuana Card?

FAMILY AND SOCIAL HISTORY

Relationship Status: ☐ In a Relationship ☐ Single ☐ Married ☐ Divorced | Length of current marriage/relationship:

Any concerns with the relationship?

Please list any recent life changes/stressful events/losses:

Where did you grow up?	Do you have a history of abuse/assault towards you of any kind? ☐ Yes ☐ No

Names/Ages of children (if applicable):

List any family psychiatric or addiction history:

DEPRESSION SCREENING QUESTIONNAIRE

Initial assessments of depressive symptoms can help determine possible treatment options, and periodic assessments throughout care can guide treatment and gauge progress. Please scan the QR code or click the link below to complete the assessment so your provider can properly prepare for your upcoming appointment.

To scan the QR code:

1. Open the camera app on your smartphone
2. Hold your smartphone camera up to the QR code
3. Click the link to open the questionnaire in your browser
4. Fill out the questionnaire and submit

URL: https://phq9web.azurewebsites.net/PHQ9/Survey/81942

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NO-SHOW POLICY

Our goal is to provide our patients with prompt and comfortable services. No-shows or late cancellations can impact the care we can provide to other patients seeking treatment. Our clinicians strive to be punctual, but given the nature of our practice, there may be delays. We require 24 business hours' notice for cancellations.

Business hours refer to weekdays from Monday to Friday. For instance, if you have an appointment scheduled for Monday at 4 p.m., you must cancel by Friday at 4 p.m. to avoid incurring any charges. Should you fail to provide at least 24 business hours notice or miss your appointment, you will be responsible for a $75 no-show fee. We understand that certain emergencies may arise beyond your control, and we encourage you to discuss any concerns with our staff in such cases. We appreciate your understanding and cooperation with these policies.

I have read and understand the above-mentioned policies and will abide by these guidelines for services at Pacific Neuropsychiatric Specialists, Inc. By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Name: _____ Signature: _____ Date: _____

CREDIT CARD AUTHORIZATION POLICY

At Pacific Neuropsychiatric Specialists, Inc., we strive to ensure our patients know all the policies and procedures in place. To ensure that insurance co-payments and fees are paid at the time of your visit, we require a credit card to be on file to process payments if needed. Should you fail to provide at least 24 business hours notice or miss your appointment, you will be responsible for a $75 no-show fee. Any balance over 60 days past due will be processed using the same method, or you may set up a monthly installment plan with office administration approval. Under HIPAA compliance, all information collected regarding payment methods remains confidential and secure within our practice environment.

Pacific Neuropsychiatric Specialists, Inc. has my permission to charge my credit card for the above-mentioned reasons, as well as any outstanding payments equal to or longer than 60 days, for the entire amount owing. I understand that my card will be manually entered, and hence no signature will be acquired, but I agree to this in accordance with the stated conditions. I will not contest costs for sessions that I did not cancel more than 24 business hours in advance. A copy of this credit card authorization will be supplied if I wish to dispute a charge with my credit card issuer.

Card type: ☐ **Amex** ☐ **Discover** ☐ **Visa** ☐ **MasterCard**

Card Number: _____

Name on card: _____ **Exp:** _____ **CVV:** _____

Billing Address (if different than primary): _____

Relationship to Patient: ☐ **Self** ☐ **Parent** ☐ **Spouse** ☐ **Other** _____

Patient Name: _____ Signature: _____ Date: _____

Signature of cardholder (if different than patient): _____ Date: _____

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PSYCHIATRIC AND PSYCHOTHERAPY INFORMED CONSENT

All practitioners are licensed in the state of California. Although psychiatric and psychological services are helpful to most patients, there are no guarantees for success. Additionally, there are some risks in psychotherapy. Patients participating in therapy may experience strong emotions such as anxiety, frustration, sadness, and anger when dealing with painful situations or unpleasant past events. Therapy may bring memories or realizations that may be distressing. Patients may experience unanticipated personal dilemmas, worries, or dreams. Thus, trying to resolve issues with important people in your life, such as your spouse/partner, child, or other family members, may result in changes that were not originally intended.

Medication: Medications are often used as adjuncts to psychotherapy and group therapy. If medication is indicated, we will discuss with you the nature of your illness, the reason for the medication, and the likelihood of improvement with or without medication. We will also explain any reasonable alternative treatment other than medication that has not been tried and explain why it should not be tried first.

The Doctor/Medical practitioner has discussed with me and/or my family the dose, ranges in dosing, as well as the frequency in which the medication(s) should be taken. We have discussed risks, benefits, and alternative treatments, as well as non-pharmacological options associated with individualized treatment. The Doctor/Medical practitioner has discussed the effects of sudden withdrawal of the drug against medical advice. I have been given ample opportunity to ask any questions related to my treatment, and I feel comfortable with the explanation given. I understand that I have the right to ask any questions about my medication(s) at any time during my treatment. I also understand that this consent is valid for as long as I am under treatment and that I have the right to refuse my medication(s) at any time by calling the Doctor/Medical Practitioner to receive an appropriate medical review. I have read this form, understand it, and consent to taking the medication(s) prescribed by the Doctor/Medical Practitioner.

Patient Name: _____ Signature: _____ Date: _____

POLICIES AND CONSENT FOR TREATMENT OF A MINOR (IF APPLICABLE)

Consent to Treat A Minor: Confidentiality in working with minors can be difficult for parents/guardians to understand. Minors won't feel safe opening up in treatment unless they can be assured that what they say will be kept private. However, as a parent, you have a right to know how your child is progressing. In general, we will advise minors that while we will be speaking with their parents from time to time, we won't share specifics unless the child and clinician(s) have agreed beforehand. The exception is when information is obtained that falls under mandated reporter status (child/dependent/elder abuse) and/or knowledge that the child is suicidal or involved in any dangerous activities. In these cases, parents and the appropriate agencies (for abuse) will be notified. The frequency of parent meetings depends on the individual and is done periodically or as issues arise. In between sessions, you are welcome to email any concerns or updates to our clinicians with respect to the time it takes outside of the office to read these concerns/requests. Please use this mode of communication, including phone contact, to convey only the most important information and any urgent issues.

Overview of Medication Management with Minors: Seeking psychiatric consultation can be an emotional and overwhelming process for parents. There is much to navigate when deciding whether medications are right for your child. Our medical specialists are very conservative with medications and will discuss all alternative treatments, the role of therapy, diet/exercise/ sleep needs, medical issues, etc. as part of a treatment plan. However, for many, medications are an essential element in treating symptoms and illnesses in mental health, just as in any other area of medicine.

We/I, the undersigned parent(s) and/or guardian(s) of a minor child, give you full authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me/us as a parent/ guardian of said child. We/I have the legal power to consent to the medical, psychological, and mental health assessment and treatment of said minor child.

Patient/Guardian Name: _____ Signature: _____ Date: _____

Witness Name: _____ Witness Signature: _____ Date: _____

TELEMEDICINE CONSENT

1. I understand that my healthcare provider may request that I engage in a telemedicine consultation.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation, which will not be the same as a direct patient/health care provider visit since I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider to operate the video equipment. The above-mentioned people will all maintain the confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and/or (3) terminate the consultation at any time.
5. I understand the difference between an in-person visit and a telemedicine visit. I have chosen the telemedicine consultation.
6. I understand that billing will occur from this telemedicine visit.
7. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions regarding the medication treatment plan.
8. My questions have been answered, and the risks, benefits, and any practical alternatives have been discussed with me in a language that I understand.

By signing this form, I certify: I have read or had this form explained to me and fully understand its contents, including the risks and benefits of the procedure(s). I have been given ample opportunity to ask questions, and any questions I have had have been answered to my satisfaction.

Patient Name: _____ Signature: _____ Date: _____

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OFFICE POLICIES AND PROCEDURES

Utilization of Advantage Healthcare Services Pharmacy: Pacific Neuropsychiatric Specialists recognizes that our patients may have questions or concerns regarding the use of a preferred pharmacy. We want to assure you that we take your health care needs seriously, and this includes providing access to quality medications in a timely manner. Advantage Healthcare Services has been selected as our preferred pharmacy for all patient prescriptions. Advantage Healthcare Services provides the best combination of convenience, customer service, cost-saving solutions, and overall patient satisfaction. All prescriptions are sent directly from our physicians to Advantage Healthcare Services. This is done in order to provide safe medical treatment while reducing the dangers associated with inaccurate or duplicate orders submitted by other pharmacies or physicians who are not affiliated with Pacific Neuropsychiatric Specialists. Advantage Healthcare Services offers next-day home delivery so that patients can get their medications without leaving their house. This convenience allows our patients to stay on schedule with taking medications on a regular basis while eliminating unnecessary travel outside of their house when traveling may be difficult due to certain mental health disorders or other factors beyond their control. We want our patients' experiences with our providers and pharmacy to be as positive as possible; however, if a patient does not wish to use our preferred pharmacy, they may decline by informing their physician at the time of their visit so that other arrangements can be made prior to the prescription being sent. We value your trust and confidence in us as we strive to meet your healthcare needs, and we appreciate your understanding and compliance with this policy.

Confidentiality and Reporting: While one of the clinician's primary duties is to protect the patient's privacy and confidentiality, this duty is not absolute or without exceptions. Communications are confidential, and generally no information will be released without your consent, except for the following: Pacific Neuropsychiatric Specialists clinicians are considered mandatory reporters for child abuse and dependent adult/elder abuse. Clinicians may also have charts subpoenaed in legal cases. However, records may be subject to patient-therapist privilege, and patient confidentiality/safety are of the utmost priority. Confidentiality is primary; however, in the case of a threat to yourself or others, we must report it.

Medical Records: Both the law and professional standards require that we keep appropriate treatment records. You are entitled to review a copy of the records, unless the clinician believes seeing them would be emotionally damaging, in which case we will be happy to provide them to an appropriate mental health professional of your choice. Clinicians may have charts subpoenaed in legal cases; however, records are usually subject to patient-therapist privilege and will only be released with your consent or a court order. You must make your request in writing. There is a fee for these copies.

Emergencies: In the event of a psychiatric emergency, such as acute thoughts of harming oneself or others or a medically dangerous reaction to a medication, our staff can be reached through the urgent numbers specified on our office voicemail. If you are facing a true clinical emergency, such as imminent danger to yourself or others, please call 911 or go to your local emergency room.

Insurance Policies: You are responsible for any amount that is not covered through insurance and charges rendered at times when your insurance is inactive. It is the responsibility of the patient to fully check their benefits and coverage before their visit(s), although our office will assist patients in navigating their benefits. If we are contracted with your insurance (an in-network provider), we must follow our contract and their requirements. We will bill your insurance as a courtesy, and after claims are received, the patient and office will receive an Explanation of Benefits (EOB) that reviews the charges and coverage. Due to the complexity of coding, you may see charges on your EOB for services or additional costs (i.e., patient education, consults, etc.). The amount due to the office is based only on the primary code billed. Please note as well that if you are choosing to use insurance for your visits, the insurance carrier may request information, such as diagnosis and copies of progress notes.

Medicare HMO Risk Opt-Out Agreement: Pacific Neuropsychiatric Specialists, and affiliated clinicians are NOT accepting new Medicare HMO risk patients. By law, Medicare-eligible patients are required to enter into a private contract with Pacific Neuropsychiatric Specialists, and we deliver medical care on a fee-for-service basis, which is not reimbursable by the HMO contracted by Medicare. By accepting the treatment contract with Pacific Neuropsychiatric Specialists, you agree that you will not submit a claim for payment under the HMO contracted by Medicare for services rendered at our office.

Prescription Refills: Prescription refill requests will be handled at the time of your appointment during regular business office hours. Prescription refills will not be handled after regular office hours or on the weekend. It is your responsibility to monitor the amount of medication that you have available. Pacific Neuropsychiatric Specialists will not refill prescription requests by phone or fax from you or your pharmacy. Pacific Neuropsychiatric Specialists medical staff will provide you with enough refills to last you until your next scheduled visit. If you do not have a follow-up appointment at that time, one will be scheduled for you. Our clinicians reserve the right to deny refills or reduce quantities/doses. Patient refills may also be denied if patients have not returned for follow-ups within the agreed timeframe. Furthermore, if accounts are past due and payment is not received, or a payment plan is initiated, clinicians' refills will be granted once, and at that point you will be responsible for any appropriate follow-up care.

Legal Testimony: It is often unforeseen, but legal matters requiring the testimony of a mental health professional can and do arise. We offer psychiatric forensic services. If, for any reason, you request, or we are subpoenaed on your behalf and required to testify or appear in court, you will be responsible for our court fees, which our office can provide upon request.

Laboratory Tests and Procedures: As part of your treatment plan, our medical staff may recommend certain lab tests/blood work be ordered to assist in diagnosis and rule out medical causes of symptoms. Our medical staff is focused on comprehensive care for you. Certain medications also require routine and periodic blood work. We work with the latest technologies to provide you with optimal care, which includes genetic testing to ascertain your body's ability to metabolize specific medications. Please make sure to discuss any physical symptoms, past medical history, etc. that may be important in your current situation. If labs are ordered, it is your responsibility to make sure that lab services are included in your insurance.

Referrals/Authorizations: If your insurance requires a referral or preauthorization, you are responsible for obtaining it. Failure to do so may result in payment denials from your insurance. Occasionally, our clinicians will refer you to another specialist. Recommendations are based on their experience with the specialist, but the specialist may/may not be an in-network provider with your insurance carrier. You will need to contact the office and/or your insurance to determine if that provider is covered.

Children and Pets: Children are very special to all of us, and we are always happy to see them, but for their safety and the courtesy of other patients, we must ask that you keep your children with you always while in our office. Pets are not allowed in the office building, except animals that are registered therapy pets.

Cell Phones and Smoking/E-Cigarettes: Please refrain from talking on your cell phone and smoking/using electronic cigarettes while in the office or waiting area. This is distracting to others around you and to the environment that we hope to create within our office. Please be mindful that there are several professional businesses within this office building and thus respect their need for a quiet environment.

Open Payments Database: The Open Payments Database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

Ambient Listening Technology: PNS utilizes a software tool that helps physicians document patient visits quickly and accurately, freeing up time for providers to focus on providing quality patient care during their appointments. Transcription software records conversations between patients and providers into text format, which is then used to create an accurate clinical note. The provider reviews the recording before signing off on the chart note. The tool does not save or use the recording after the visit, and medical record information is kept private and only accessible to PNS

By signing below, I acknowledge that I have read the above office policies and procedures, consent to treatment with Pacific Neuropsychiatric Specialists, and agree to abide by any of the terms during our professional relationship.

Patient Name: _____ Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

This notice explains how your medical information may be used and shared and how you can access it. It is important to read it carefully. A full version is available upon request. If you have any questions, ask our administrative team. The information is current as of September 2023 and will be valid until updated.

All clinicians and office staff at Pacific Neuropsychiatric Specialists are committed to protecting the privacy of protected health information for our patients and clients. Protected Health Information (PHI) refers to information in your health record that could identify you. It is individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care.

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the HIPAA Privacy Rule, we are permitted to use and/or disclose your PHI for the purposes of treatment, the payment for services you receive, for health care operations, appointment reminders, treatment alternatives, health-related benefits and services, individuals involved in your care, worker's compensation, public health risks, as required by law, and to avert a serious threat to health or safety. For most uses and/or disclosures of your PHI, you will be asked to grant your permission via a signed authorization to release information.

2013 Omnibus HIPAA Final Rule (Update to HIPAA): New privacy standards were adopted in 2013 to further clarify and protect patients' health information and confidentiality when it is disclosed, as well as facilitate the flow of medical information between providers. Please read the following so that you understand your rights as a patient as well as the new rules about patient confidentiality. Feel free to ask about privacy, confidentiality, or psychiatric records.

Updates to previous HIPAA policies include the following:

- Permission from the patient is no longer required for the transfer of psychiatric and medical information between providers, as long as only the necessary information is supplied. Collaboration of care agreements signed in the office can help to specify this better.
- Psychotherapy notes are not authorized to be released without patient consent, and even if consent is obtained, our office often prefers to complete a treatment summary instead to protect your privacy and also better facilitate care.
- Substance abuse records from alcohol/ drug programs are exempt from any disclosure without patient permission. If you (or your child) are admitted to a treatment program for substance abuse, be sure to sign a release so that we can talk to the providers and obtain a discharge summary and laboratory data upon discharge. Without this, we cannot obtain any information.
- We may have to disclose some psychiatric information when required to do so by law without your consent. This includes mandated reporting of child/ elder abuse and cases of legal order or subpoena (see confidentiality in Office Policies).
- National security and public health issues. We may be required to disclose certain information to military authorities or federal health officials if it is required for lawful intelligence, public health safety, or public security.

Patient Rights Regarding Your Protected Health Information (PHI) and Psychiatric Records:

- Right to Inspect and Copy Your Medical Information: All patients have the right to inspect and copy their own protected health information (medical record) on request, except for mental health records, which must be reviewed with the clinician first. In cases where exposure to the record might be harmful to the patient, the clinician may deny the request. If you request a copy of your psychiatric record, we will generally review the record with you. It is unlikely that there would be information in the chart that a patient should not or could not read, but much of the information in the chart may require explanation.
- Right to Request an Amendment: of information you consider incorrect or incomplete
- Right to an Accounting of Disclosures: that we have made medical information about you
- Right to Request Restrictions: or limitations on the information we use or disclose about you for treatment, payment, or health care
- Right to Receive Confidential Communications: as specified by you and also by alternate means or locations
- Right to a Paper Copy of This Notice
- Changes to the Notice: We reserve the right to change this notice and will post a dated copy in the office
- Complaints: If you believe your privacy rights have been violated, you may file a complaint with the office manager or with the Department of Health and Human Services. You will not be penalized for filing a complaint

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, have received a copy of the summary of the Notice of Privacy Practices, and I am aware of my right to have a full copy of the entire HIPAA policy if desired.

Patient Name: _____ Signature: _____ Date: _____