

PEACE OF MIND COUNSELING, LLC

Client Intake Form – Adult (18 & Older)

TODAY'S DATE _____

CLIENT NAME _____

RESPONSIBLE PERSON
NAME _____

BIRTHDATE _____

RELATIONSHIP TO CLIENT _____

ADDRESS _____

ADDRESS _____

CITY _____ STATE _____

CITY _____ STATE _____

ZIP _____ County of Residence _____

ZIP _____ County of Residence _____

GENDER: (circle one) Male Female Self-Identify

PRIMARY PHONE: _____ Home Cell Work Other Okay for us to leave a message? No Yes

OTHER PHONE: _____ Home Cell Work Other Okay for us to leave a message? No Yes

May we contact you by e-mail? No Yes If yes, Email Address: _____

May we contact you via text? No Yes At which number: _____

Texting and email are for scheduling and correspondence, not for therapy. All efforts will be made not to include any personal or identifying information in electronic correspondence. We do not add clients to social media.

CLIENT MARITAL STATUS: (Circle one)	SINGLE	MARRIED	DIVORCED
	SEPARATED	DOMESTIC PARTNER	WIDOW/ER
EMPLOYED: (Circle one)	FULL TIME	PART TIME	SHELTERED EMPLOYMENT
	HOMEMAKER	UNEMPLOYED	STUDENT
			RETIRED

EMPLOYER: _____

How did you hear about our services? Online Friend/Family Phone book
Other _____ Referred by _____

EMERGENCY CONTACT:

Name _____ Relationship to client _____

Phone _____ Do we have permission to call this person if we feel client is experiencing an emergency situation? Y N

CLIENT'S CURRENT MEDICATIONS: _____

ALLERGIES or serious medical conditions? (List) _____

PHYSICIAN (Name and clinic) _____

Do we have permission to contact client's physician? Yes No

Staff only: ROI Signed Y N

All counseling appointments are scheduled in advance. We reserve a specific time period (usually 50 minutes) to each client. It is important that you realize that a block of time has been set aside for you. If an appointment is not canceled ("No Show"), you may be charged for the time set aside for you.

Financial Agreement

Self Pay: I do not have insurance or other third-party coverage. I will pay for the services I receive at Peace of Mind Counseling, LLC. I will make a payment of \$ _____ each time I come for services; if there is any balance it will be due each month.

Note: If you choose to use this Self Pay option, this clinic will not re-bill any insurance at a later date.

Insurance payment: I will give all insurance information required to Peace of Mind Counseling, LLC staff, including an outside billing agency, and request that they submit the charges to my insurance company for payment. I understand my insurance may not pay in full or may deny my services. I understand that I am financially responsible for all charges. This includes my deductible and/or copay. I authorize this clinic and its billing agency to furnish to my insurance company all information that may be required in order to process the claims for me and/or my dependents.

Regardless of your payment method, any uncollected balances may be forwarded to a collection agency.

Please present your insurance card at time of initial appointment and fill out the following thoroughly:

Name of Insurance: _____

Address of Insurance Company: _____

Policy ID# _____ **Group #** _____

Name of Policy Holder: _____

Address of Policy Holder: _____

Date of Birth of Policy Holder: _____ **Employer:** _____

Assignment of Benefits

I hereby direct my insurance company to pay for my services by check made out and mailed to:
Peace of Mind Counseling, LLC; 115 5th Ave. So. #523; La Crosse, WI 54601

If my current policy prohibits direct payment to provider, I hereby also instruct and direct my insurance company to make the check out to me and mail it to the above aress for the professional expense benefits allowable, and otherwise payable to me under my current policy as payment toward the total charges for services rendered. This is a direct assignment of my rights and benefits under this policy. I have agreed to pay any balance of said charges for professional services over and above this insurance payment. A copy of this assignment shall be considered as effective and valid as the original.

I have read and understand my Rights and Responsibilities as written in the "Client Information Booklet."
I have read and understand the above financial policy of Peace of Mind Counseling, LLC.

Client signature (if age 14 or older): _____ Date: _____

Parent or guardian signature (if client is a Minor): _____ Date: _____

For Clinical Staff use only:

Witness/Therapist Signature: _____ Date: _____

Initial Dx: _____

Peace of Mind Counseling

Informed Consent Notice

Risks and benefits:

When receiving treatment for mental health problems there are both risks and benefits. Risks or side effects may include discomfort from sharing personal information, or discomfort from trying/applying treatment strategies to your daily living routine. There may also be times of strong unpleasant feelings. This is a normal part of the counseling process and can be discussed with your therapist at any time.

There are also clear possible benefits. Benefits may include: increase in ability to cope with stressors, a decrease in mental health symptoms, better relationships, increased self-understanding and acceptance, and an overall feeling of being understood and unconditionally accepted. In short, you may feel better and get along with people better.

As a client or guardian of a client, you have numerous rights (see next page). You have the right to refuse or decline any proposed treatment methods or services. However, your refusal may result in, among others, symptoms or problems intensifying or becoming chronic, or symptom relief may take longer to achieve.

Confidentiality:

During the course of serving you, Peace of Mind Counseling may find it necessary to share information with other health care or business associates. Reasons we might share information include:

- Use of a billing service to receive payment *

- Health insurance requests for information *

 - *Your permission is granted if you sign our intake form

- Therapists who are receiving supervision will consult with Supervisor as required. Licensed therapists will engage in peer review or professional collaboration to ensure you are receiving high quality care

Confidentiality of your information will be disclosed without your consent in these instances:

- In certain situations involving suicide or threatening another person's life

- The possibility of abuse or neglect of a child or vulnerable adult

- Court ordered release of records

Peace of Mind Counseling adheres to all Federal, State, and local laws and regulations regarding Privacy Practices. Any disclosures of information other than those listed above (including sharing information with your other care providers) will only be released with your written authorization. You may revoke that authorization at any time in writing.

Treatment:

On the first day, you will be asked to fill out forms that provide us with your personal demographic information as well as why you are seeking treatment, symptoms, and other questions about your past and present that inform us in an effort to provide you with best care. You may also be asked questions regarding your family, current or past relationships, previous counseling, medications, and more. This information will be kept confidential as described above.

Generally you will receive a diagnosis at the first session, which allows the therapist to develop a treatment plan with you. Your therapist will discuss treatment approaches to address your symptoms or struggles. Treatment approaches used within this agency include, but are not limited to, Cognitive-Behavioral Therapy, Choice Theory, Relaxation/Anxiety Reduction, Play Therapy, and Family Therapy. It may take time and several strategies to find the best method for you as an individual. Discussing your goals and strategies/options is an important part of your active participation in the counseling process.

Summary of Client Rights: *All consumers of outpatient mental health services are guaranteed the following rights under Wisconsin State law:*

- Nondiscrimination on the basis of race, religion, age, sex, or sexual orientation, ethnic origin, physical or mental impairment, financial or social status.
- The right to the least restrictive treatment conditions necessary.
- The right to receive prompt and adequate treatment.
- The right to be free from any unnecessary or excessive medications at any time.
- The right to be informed of your treatment and care and to participate in the planning of your treatment and care.
- The right to a humane psychological and physical environment.
- The right to confidentiality of all treatment records, to review and copy certain records, and to challenge the accuracy, completeness, timeliness or relevance of information in your records in accordance with the provisions of DHS35.
- Be informed about the costs of treatment.
- The right to file a grievance about violation of these rights without fear of retribution.
- The right to go to court if you believe that your rights were violated.
- The right to be treated with respect and recognition of the patient's dignity and individuality by all employees of the treatment facility or community mental health program and by licensed, certified, registered or permitted providers of health care with whom the patient comes in contact.

Source: Ch. 51 Wisconsin Statutes

You have also received a client rights brochure which explains your rights more completely and lists persons to contact if you have a complaint or grievance.

Consent:

I have read and understood the policies and confidentiality exceptions described herein. I am requesting professional services from Peace of Mind Counseling. I understand that I can ask questions or discuss concerns at any time regarding my treatment with my counselor or their supervisor. I also understand I may terminate counseling or withdraw this consent at any time for any reason, but the withdrawal must be in writing and signed by me or my legal guardian.

and

I have been informed of my rights as a client and given the opportunity to ask questions.

Client Name (print) _____

Client Signature (if age 14 or over) _____ *Date* _____

Parent or Guardian signature (if relevant) _____ *Date* _____

Therapist Signature _____ *Date* _____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: _____ Sex: Male Female Date: _____

If this questionnaire is completed by an informant, what is your relationship with the individual? _____
 In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Peace of Mind Counseling, LLC
Personal History Form

In the following form, "you" refers to the client:

Your (Client's) Name _____ Today's Date _____

Gender F ___ M ___ Self-Identify ___ Date of Birth _____ Current Age _____

Form completed by (if other than client)

Relationship _____

HOME ENVIRONMENT: With whom do you live?

Full Name	Age	Relationship to you
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If not included above, how many siblings do you have? _____ Are your parents living? _____

Were you adopted? Y N At what age? _____

WORK/SCHOOL: School attended, highest grade or degree achieved _____

Describe any learning difficulties in elementary or high school _____

Place of employment / type of job _____ Schedule _____

Do you experience difficulties at school and/or work? If so, explain _____

REASON FOR COUNSELING: Briefly explain your issues of concern _____

Length of time you have had these concerns _____

How would you rate the intensity of the concern? (1=Mild, 5=Moderate, 10=Extreme) 1 2 3 4 5 6 7 8 9 10

Describe ways you have attempted to cope _____

What would you like to see accomplished through counseling (your goals)? _____

Medical History: Any medical concerns you have _____

Any significant medical concerns in your family _____

List any known allergies you have, including allergies to medication _____

Your primary physician and clinic/hospital location _____

Previous Counseling: Have you ever participated in counseling services prior to this occasion? Y N

When _____ Approx.# of sessions _____

Therapist and clinic _____

Was it helpful? Y N Why or why not? _____

Have you taken any medications for *mental health* symptoms? Y N

Medication _____ For what symptom _____ How long _____
_____ For what symptom _____ How long _____
_____ For what symptom _____ How long _____

Are/were you satisfied with the outcome of medication treatment? Y N

List current medications you take for *physical* symptoms _____

Legal History: List any past legal involvement, crimes you have committed _____

Military History: Y N If yes, Branch, year(s) served, other details _____

MOODASSESSMENT: Check if you have or are experiencing problems with any of the following:

Impaired: Concentration _____ Thinking _____ Reasoning _____ Perception _____ Memory _____

Depressive Symptoms: Negative thoughts _____ Lack of energy _____ Restlessness or Mania _____
Appetite increase _____ Appetite decrease _____ Any change in weight: Up _____ lbs. or down _____ lbs.
Increased sleep _____ Decreased sleep _____ Avg. # hrs. sleep/night _____

Suicidal Symptoms: Preoccupation with death _____ Talked about suicide or had suicidal thoughts _____

Number of previous attempts _____ Specific action _____

Do you habitually cut, burn or otherwise harm yourself without intent to die? Y N Describe _____
_____ How frequently? _____

Anxiety Symptoms:

List signs of anxiety, describe _____

Name the source of the anxiety, if known _____

Do you have a history of panic attack(s)? Y N

Describe what was happening at the time _____

Obsessive or Compulsive Symptoms: Y N Explain _____

Anger: Short temper or trouble controlling anger? Describe _____

Did either parent have trouble controlling anger? Y N History of domestic violence in your family? Y N

Have you had any significant consequences or legal charges due to anger/domestic violence Y N

Describe _____

Alcohol or Substance Use/Abuse History: How often do you drink alcohol? _____

Have any family members had problems with alcohol abuse? Y N Who? _____

Have you ever experimented with drugs/other substances? _____ Which one(s)? _____

Consequences (self, family, health, legal) _____

Is anyone close to you concerned about your use of alcohol or other substances? Y N Who? _____

Abuse History: Have you experienced any of the following types of abuse in the past or present?

Sexual abuse _____ Physical abuse _____ Emotional abuse _____ Verbal abuse _____

Describe _____

Family and Social Functioning:

Do you have close friends? _____ How often spend time together? _____

Which family member(s) are you close to? _____

Which family member(s) are you in frequent conflict with? _____

Your favorite activities or hobbies _____

Sexuality: Do you identify as LGBT? _____ Do you have any sexual concerns? _____

Religious Affiliation: Do you have a religious affiliation? Y N Describe _____

What are your personal strengths? _____

What are your personal struggles or weaknesses? _____

Thank you for filling out this form! It will help us understand you and serve you better.

Peace of Mind Counseling, LLC 115 5th Ave. So. Suite 523 La Crosse, WI 54601

Peace of Mind Counseling, LLC

Personal History Form

For clients under 18 years of age

Was the child born prematurely or with any complications at birth? Y N Describe _____

Any significant events during infancy or childhood that affected child's overall development? _____

At approximately what age was the child able to do the following? If you do not remember the age, indicate "E" (Early) "N"(Normal) or "L"(Late) compared to other children.

Crawl _____ Sit up by self _____ Weaned _____ (Breast or bottle?) _____

Walk _____ Talk _____ Dressed self _____ Slept through the night _____

Toilet trained _____ Spoke 4-5 word sentences _____

Other developmental milestones the child achieved earlier or later than most _____

Emotional/Behavioral History Check any that this child has experienced or displayed to a concerning level

Thumb sucking _____ Nail biting _____ Separation anxiety _____ Clingy _____

Whining _____ Irritability _____ Quick to anger _____ Tantrums _____

Biting others _____ Worrying _____ Afraid of dark _____ Nightmares _____

Tics _____ Bedwetting _____ Soiling other than in toilet _____

Sleepwalking _____ Hyperactivity _____ Other (describe) _____

Difficulty with: Getting to sleep _____ Staying asleep _____ Staying on task _____

Making or keeping friends _____ Bullies others _____ Victim of bullying _____

Sharing _____ Following directions _____

Fear of social situations _____ Unusual fears/phobias (List) _____

Education:

Did the child attend Head Start? Y N Preschool? Y N # of years _____

Does the child have an IEP? If yes, for EBD ___ LD ___ CD ___ OHI ___ Spch/Language _____

Describe IEP accommodations _____

Is child attending regular school or special location? If so, where? _____

Other:

Has the child had any legal or delinquency problems? Describe _____

Has the child received any other special services (mentor, respite care, foster care, County Social Worker, etc) _____

Any other emotional or behavioral concerns? _____

Please fill out
Sections A, C, and F.

Peace of Mind Counseling, LLC
115 5th Ave. So. #503; La Crosse, WI 54601

Release of Information: Authorization For Disclosure of Client Information

A { Client Name: _____ DOB: _____
Address: _____ Phone: _____

B { **Hereby Authorizes:** Peace of Mind Counseling, LLC
Address: 115 5th Ave. So. #503 City, State, Zip: La Crosse, WI 54601
Phone: _____ Fax: 608-782-4426 Email: _____

C { **To:** **Receive from** **Release to** **Exchange with** **Includes verbal exchange**
Name of Primary Care Physician Receiving the Request _____
Street Address: _____ City, State, Zip: _____
Phone: _____ Fax: _____ Email: _____

D { **Information Requested:**
I understand that this will include:
 Complete health record(s) Client History
 Discharge Summary Consultation Reports
 Progress Notes/Case Notes Diagnostic Assessment
 Prescriptions Other (specify) _____
Relating to:
 Mental and Behavioral Health
 Developmental Disabilities
 Treatment for alcohol and/or drug abuse
 Education
 Other _____
Covering the Time Period(s): from _____ to _____

E { **For the purpose of:**
 Coordination of health care
 Insurance purposes
 Legal Investigation -
 Personal
 Other (specify) _____
Your Rights with Respect to this Authorization
--Right to Inspect or Copy the Health Information to be Used or Disclosed
--Right to Receive Copy of This Authorization
--Right to Refuse to Sign-I understand I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for healthcare benefits on my decision to sign this form
Information may be subject to redisclosure and no longer protected by the regulation.

F { I understand this authorization may be revoked in writing at any time. This authorization will expire one year from the date of my signature or otherwise designated date of _____. If I elect to revoke this authorization prior to its annual renewal date, or the designated date I selected, I understand that Peace of Mind Counseling cannot be held responsible for any records already released prior to written notification, to the appropriate employee, that I am revoking my consent.

The facility, its employees and therapists are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. By signing this authorization, I confirm that it accurately reflects my wishes.

F { **Your signature to disclose this information allows Peace of Mind Counseling to release your information by means of USPS, fax, telephone, and email.**
Signed (Client if 14 or older): _____ Date: _____
Signed (Parent or Guardian, if applicable): _____ Date: _____
Witness (Peace of Mind Counseling staff member): _____ Date: _____

Client is: A Minor Incompetent Disabled Deceased
Signer is: Legal Authority Custodial Parent Legal Guardian Power of Attorney Legal Authorized Representative

JOINT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY.

This information is available in Spanish and Hmong. Please ask a staff member if you need a copy in either of these languages. Esta información esta disponible en español. Se usted necesita una copia en español, por favor pregunte a miembro del personal. Cov ntau ntaav no nws muaj cov pes lus hmoob. Yog tias koj xa tau ib daim ntaav uas pes lus hmoob no thov noog cov neeg ua hauj lwj.

When we refer to “you” or “your” in this Notice we refer to the person or persons receiving the services provided by Peace of Mind Counseling (PoM). When we refer to disclosures of information to “you”, we mean disclosures to adults or children, the parent of the children, guardian or other person legally authorized to receive information about the person or persons receiving services from Peace of Mind Counseling.

Who follows this Notice:

This Notice applies to all **protected health information (PHI)** maintained by Peace of Mind Counseling (PoM) for services provided at any office of PoM or services provided at non-office locations by any employee of PoM in the course of their employment. If you have any questions after reading this Notice, please contact the Peace of Mind Counseling Privacy Officer listed at the end of this document.

Each time you receive services from Peace of Mind Counseling, a record of the services provided is created. Typically this record could contain information about the type of service you have received, the dates of service and the results of the service provided. At times this will include the reason you have come to PoM for service and the agreed upon goals of the service provided.

This Notice applies to all of the records containing PHI created as a result of services provided by Peace of Mind Counseling.

Our Pledge to Protect Your Health Information: We are required by law to maintain the privacy of your PHI and provide you with a description of our privacy practices.

We reserve the right to revise or change this Notice. Each time you sign a consent for treatment at a site covered by this Notice we will provide a copy of this Notice in effect at that time.
Effective March, 2016

Right to Amend or Correct Your Record: If you feel the PHI we have about you is incorrect or incomplete, you may ask us to amend the information for as long as the information is maintained by Peace of Mind Counseling. Requests for amendment or correction should be made by submitting a form requesting amendment or correction available from the Privacy Officer. We will respond to your request within 60 days after you submit the form. We are not required to agree to the amendment.

Right to an Accounting of Disclosures: You have a right to request an accounting for disclosures. This is a list of those people with whom Peace of Mind Counseling may have shared your PHI, with the exception of information shared for purposes of treatment, payment or health care operations or when you have provided us with an authorization to do so. We may charge you a reasonable fee if you request more than one accounting for disclosures in any 12-month period. The request cannot include any disclosures made before April 14, 2003. Requests for an accounting of disclosures should be made in writing to the PoM Privacy Officer. We will respond to your request within 60 days after you submit the request.

Right to Request Confidential Communications: You have the right to ask that we communicate your PHI to you in a certain way or a certain location. For example, you can request that we contact you only at work or by mail. We will accommodate reasonable requests.

Right to Revoke Authorization: Uses and disclosures of PHI not covered by this Notice or the laws that apply to Peace of Mind Counseling will be made only with your authorization. If you authorize PoM to use or disclose your PHI, you may revoke that authorization in writing at any time. We are unable to reverse any disclosures we have made previously with your authorization. To revoke an authorization please contact your therapist or the clinic where you receive services.

Right to Complain: If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. To file a complaint with Peace of Mind Counseling, contact the Privacy Officer. All complaints must be made in writing. The Privacy Officer will assist you in filing your complaint. Filing a complaint will not affect your care.

Who to contact with a complaint or grievance:

Cindy Ericksen, Client Rights Officer 608-785-0011

Secretary of Department of Health and Human Services: (877) 696-6775

Required or Permitted by Law: Peace of Mind Counseling is required by law to disclose your PHI in certain circumstances:

- For public health oversight activities
- To facilitate the functions of federal or state governmental agencies
- To report suspected elder or child abuse to law enforcement agencies responsible to investigate or prosecute abuse
- In response to a valid court order
- To the Department of Health and Family Services, a protection or advocacy agency, or law enforcement authorities investigating abuse, neglect, physical injury, death or violent crimes
- To your court-appointed guardian or an agent appointed by you under a health care power of attorney
- Prison officials if you are in custody
- Worker's Compensation officials if your condition is work-related
- If necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public

When sharing PHI with others outside of Peace of Mind Counseling, we share only what is reasonably necessary unless we are sharing PHI to help treat you, in response to your written permission, or as the law requires. In these cases, we share all the PHI that you or the law requires.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your PHI we maintain. To exercise any of the rights discussed in the remainder of this section, please contact the Privacy Officer for Peace of Mind Counseling.

Right to Request Restrictions: You have the right to request certain restrictions of use and disclosure of your PHI by Peace of Mind Counseling for treatment, payment or health care operations. You also have the right to request a restriction on our disclosure of your PHI to someone who is involved in your care or the payment for your care. PoM is not required to agree to restrict the use and disclosure of your PHI. A request for restriction must be made in writing using the form available from the Privacy Officer.

Right to Inspect and Copy: With a few exceptions you have the right to inspect and receive a copy of your PHI. Should you wish to review or copy your PHI you should make a request using the form available from the PoM Privacy Officer. We will arrange for your therapist or another health professional in our clinic to review the PHI with you in our office or to copy the information requested. We may charge you a reasonable fee if you want a copy of your PHI.

How We May Use and Share Your Health Information With Others

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. For example, a worker or therapist may use PHI about you or your child from a clinic record to determine which treatment option, such as family or individual therapy, best addresses your needs. Your worker or therapist may discuss information found in your record with our consultants, a colleague or their supervisor to assist in treatment planning for you or your child.

For Payment: We may use and disclose PHI to send bills and collect payment from you, your insurance company, or other payors, such as governmental agencies, for the treatment or other related services you receive from Peace of Mind Counseling so PoM can receive payment for the treatment services provided to you. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing and sending claims to your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

For Health Care Operations: We may disclose PHI about you for business operations of Peace of Mind Counseling. These uses and disclosures are necessary for PoM to provide quality care and cost-effective services. The operations where we may need to disclose PHI includes, but is not limited to, quality assessment activities, employee review activities, and licensing activities. For example, we may share your PHI with third parties that perform various business activities (such as billing or typing services). We will require these third parties to have a contract with us that requires them to safeguard the privacy of your PHI. Quality assessment activities may include evaluating the performance of your therapist or examining the effectiveness of treatment provided to you when compared to patients in similar situations.

Future Communications: We may use your name, address and telephone number to contact you to provide newsletters, information about programs or other services we offer. Your information will never be given to anyone outside of our agency.

Appointments: We may use your PHI for the purpose of sending to you appointment reminders through the mail or by telephone. Messages left for you will not contain specific health information.