Office Policies & Service Agreement

Office of

David NeeSmith, Ph.D. & Associates

Authentic Living
& Relationships.

NOTICE OF IMPORTANT INFORMATION

This document contains the policies for the Office of Dr. David NeeSmith & Associates. We provide these policies in advance so that clients will have a clear understanding of how this office operates prior to beginning services. If you have any questions or anticipate potential conflicts with any of these policies, please discuss them with us or consult an attorney prior to signing this binding agreement. Additionally, if you have any questions in the future, please discuss them with us at your soonest convenience.

Please read the sections below carefully and completely. If you have any questions, please discuss them during your first appointment. Areas highlighted in yellow require your initial or signature. We will assume from your participation in our services that you have a full understanding of the following sections.

David NeeSmith, Ph.D. & Associates

Authentic Living & Relationships

California License PSY14179

1151 Dove Street, Suite 204 • Newport Beach, CA 92660 • Office: (949) 263-8885 • Fax: (949) 263-8877 • www.DavidNeeSmith.com • Doc@DavidNeeSmith.com

Client Information

NAME (OR PARENT OF MINOR)_____ DATE_____

MAILING ADDRESS_____ ZIP_____

HOME PHONE_____ WORK PHONE_____

MOBILE PHONE_____ PAGER_____ EMAIL_____

DOB_____ PLACE OF BIRTH_____ ETHNICITY_____

MARITAL STATUS ❍ Single ❍ Married ❍ Separated ❍ Divorced ❍ Widowed ❍ Domestic Partnership_____

EDUCATION (YEARS)_____ DEGREE_____ AREA_____

OCCUPATION_____ EMPLOYER_____

SPIRITUAL / RELIGIOUS ORIENTATION_____

I ATTEND RELIGIOUS SERVICES ❍ Never ❍ Rarely/Special Occasions ❍ Monthly ❍ Weekly

NAME OF SPOUSE/PARTNER_____

ADDRESS_____ ZIP_____

HOME PHONE_____ WORK PHONE_____

MOBILE PHONE_____ PAGER_____ EMAIL_____

DOB_____ PLACE OF BIRTH_____ ETHNICITY_____

EDUCATION (YEARS)_____ DEGREE_____ AREA_____

OCCUPATION_____ EMPLOYER_____

SPIRITUAL / RELIGIOUS ORIENTATION_____

I ATTEND RELIGIOUS SERVICES ❍ Never ❍ Rarely/Special Occasions ❍ Monthly ❍ Weekly

NAMES OF CHILDREN:	DOB:	AGE:	NAMES OF CHILDREN:	DOB:	AGE:
1			4		
2			5		
3			6		

FAMILY PHYSICIAN_____ PHONE_____

ADDRESS_____ ZIP_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____

RELATION_____ PHONE 1_____ PHONE 2_____

ADDRESS_____ ZIP_____

WHO REFERRED YOU TO THIS OFFICE?_____

MAY WE CONTACT THIS PERSON TO THANK HIM/HER FOR THE REFERRAL? YES / NO (INITIAL):_____

1. Arbitration Agreement

It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Initial (Each adult client)l: _____ _____ _____ _____ _____ _____

2. Confidentiality Policies

Confidentiality is the legal right to privacy for all clients who receive psychological services. That is, all personal information presented in this office will not be discussed with persons or agents outside of this office except as authorized by a written release or as required by law. However, there are exceptions to confidentiality. Understand that all information discussed in this office will remain confidential *except* under the following circumstances:

- You consent in writing for Dr. NeeSmith & Associates to release and disclose information.
- A breach of confidentiality is required or permitted by law. Examples include instances in which Dr. NeeSmith & Associates have a reasonable suspicion of child abuse, elder/dependent adult abuse, dangerousness toward self or others, and other matters subject to law.
- Dr. NeeSmith & Associates in their discretion decide to obtain consultation on your case with a colleague or legal counsel, in which case no identifying information will be revealed.
- You fail to make regular payments on your outstanding bill, which can result in your bill being turned over to a Collection Agency or submitted to Small Claims Court.
- This is a Social Service Agency case, wherein all information shared with Dr. NeeSmith & Associates will be conveyed to the assigned Social Worker and/or other SSA representatives and agents.
- If you are a party in litigation, including divorce litigation, and you tender your mental condition as an issue, your privilege may be waived. In custody cases, you may be required to waive your privilege to facilitate an evaluation by a court ordered evaluator. Dr. NeeSmith & Associates may be required to produce your records and/or testify at deposition or trial if we are served with subpoenas or court orders. We cannot give you legal advice as to what actions may or may not waive your privilege.
- Please be aware that under California's Family Code, a parent without custody may still be entitled to information about his or her child's treatment.
- We frequently contact clients by Cellular Phone and Email. These technologies are **not** guaranteed of privacy. *Please circle whether you authorize contact by Cell Phone and Email:* YES / NO Initial: _____.

NOTE TO PARENTS ABOUT CHILDREN'S CONFIDENTIALITY: If your child participates in treatment, please understand the importance of allowing him/her to develop a confidential relationship with his/her therapist. As such, you understand that most personal information that your child discusses with his/her therapist will not ordinarily be shared with you. Rather, your child's therapist will provide you with *general summaries* of your child's progress without private details. However, understand that this office is committed to informing you about unusual or dangerous symptoms or behaviors (such as violence, child abuse, self-abuse, suicidality, or intentions to harm others, harm oneself, drive while intoxicated, etc.).

3. Financial Policies

PROFESSIONAL SERVICES AND RATES. Our professional services and rates are as follows:

PROFESSIONAL SERVICES:	TIME:	RATES for David NeeSmith, Ph.D.:	RATES for Michael Toppen, M.A.:
◆ Intake Interview (first appointment):	45-50 minutes 75 minutes 90 minutes	$210 $295 $340	$150 $210 $270
◆ Psychotherapy:	45-50 minutes 75 minutes 90 minutes	$170 $255 $300	$120 $180 $220
◆ Missed Appointment or Late Cancellation Charge (see below):	50 minute session 75 minute session	$170 $255	$90 $135
◆ Supervision, Consultation, & Licensing Exam Coaching:	45-50 minutes	$170	N/A
◆ Report Writing: *(Treatment summaries, letters, etc.)*	Prorated.	$200 per hour	$120 per hour
◆ Court-Related Services: *(Any court-related services, including evaluations, depositions, conferencing, testimony, preparation, standby and travel time, reports to be used for legal purposes, etc.)*	Prorated. *Half-Day minimum for court attendance or standby status. Retainer required in advance.*	$350 per hour	$250 per hour
◆ "Relational Parenting" Workshop: (8-Week, 16-Hour course)	Please call for workshop dates.	$595 per person; $995 per couple (*includes all materials*).	

FINANCIAL RESPONSIBILITY. Please use the following table to specify who will be financially responsible for services. Adults seeking and paying for their own individual therapy will typically designate themselves as solely (100%) responsible. However, couples and families (especially divorced parents) frequently divide financial responsibility. Divorced parents are customarily billed 50% of each session involving their children, but these parents are charged 100% of private parent sessions in which they come in to discuss their children or parenting strategies. Specifying in advance exactly who will be financially responsible will help us bill the appropriate parties.

RESPONSIBLE PARTIES (PRINT NAME):	Percentage of Services responsible for:	Do you wish to receive a Monthly Statement?	Do you need extra invoices to attach to Insurance Claims?	SIGNATURE:
	%	Yes No	Yes No	
	%	Yes No	Yes No	
	%	Yes No	Yes No	
*For divorced parents whose children are receiving therapy: Do you prefer to pay 100% of sessions in which you come in alone to discuss your child's problems, progress, or parenting strategies? *Please check one:*				❍ Yes. ❍ No.
*For parents of adolescents (16 years of age and up) and adult children: If your child is independently scheduling and attending therapy sessions and he/she misses or cancels an appointment at the last minute, do you prefer that we bill you or your child for the corresponding "Missed Appointment" or "Late Cancellation" charge? *Please check one:*				❍ Bill "Late Cancellation Fees" to My Teen/Adult Child. ❍ Bill "Late Cancellation Fees" to Parties as usual.

PLEASE PAY BY CHECK. Please make checks payable to "**Dr. David NeeSmith**" and present them at the beginning of your session. If you receive services from Mr. Toppen, this Associate is employed by Dr. NeeSmith and California Board of Behavioral Science Examiners' regulations require that all checks be made payable to their employer. If you need to pay by cash and would like a receipt, please request a receipt at the beginning of the appointment, or you may wait to receive your monthly invoice that will show all payments made.

PROMPT PAYMENT. Fees are due when services are rendered. This office provides monthly statements which clients may submit to their insurance companies for reimbursement. Therefore, any remuneration from insurance companies will be made payable to you. Balances not paid within 30 days are "PAST DUE." Balances not paid within 60 days may be sent to our collection agency or pursued through Small Claims Court. If you are not able to make a full payment, you agree to make regular monthly payments (minimum of $100.00) until all fees are paid.

INSURANCE CLAIMS. You are obligated to pay for services regardless of which charges your insurance company covers. You have the right to verify coverage with your insurance company prior to beginning services. The filing of insurance claims is your responsibility, except where information must be furnished by the provider, in which case Dr. NeeSmith & Associates will gladly fill out the information.

Missed Appointment or Late Cancellation Charge. You agree to pay a Late Cancellation Fee for any missed appointment that you do not call to cancel at least ***24 hours in advance*** and ***by Friday 5:00 PM for Monday appointments***, except in the case of verifiable emergencies. Please understand that Cancellation Fees are customarily not covered by insurance. If you cancel an appointment less that 24 hours in advance and we can fill the slot, you will not be charged. We will do our best, but please note that people on our waiting list cannot always accommodate short notice.

Telephone Calls, E-Mails, & Crisis Counseling. Dr. NeeSmith & Associates do not charge for telephone calls to schedule or change appointments. However, if you ever decide to contact Dr. NeeSmith & Associates by phone or by email to discuss clinical issues or concerns, to get advice, to obtain resources, or to receive crisis counseling, you will be charged by the minute. Telephone & Email charges will show on your monthly statements, and insurance may not cover these telephonic charges.

Return Check Fee. Returned check fee is $35.

Right To End Therapy. You have the right to end therapy at any time with no obligation except to pay for completed services.

4. Informed Consent

Dr. NeeSmith provides psychotherapy as a licensed psychologist in the state of California. His associate, Michael Toppen, M.A., MFTI provides psychotherapy within the scope of Marriage & Family Therapists under the supervision of Dr. NeeSmith.

About Psychotherapy. Psychotherapy is both an art and science that is usually helpful to people who wish to improve their lives. People may enter therapy to increase self-awareness, gain a better understanding of personal goals and values, improve relationships, resolve many kinds of personal traumas or dilemmas, and develop skills in areas of assertion, boundaries, communication, problem solving, and emotional management. Research shows that many people who enter therapy find that it helps them in some way.
A person's outcome from therapy is improved by putting forth a sincere effort, being honest with oneself and with his/her therapist, being open to feedback, and being willing to follow through with recommended readings and therapeutic assignments.

Potential Risks & Benefits. Although psychological services are helpful to most clients, there are no guarantees of success. Furthermore, there are some risks in psychotherapy. People who receive psychological testing may have difficulty learning that they have a particular psychiatric diagnosis that they find unexpected or distressing. Persons participating in therapy may experience strong emotions such as anxiety, frustration, sadness, and anger when dealing with troubling situations or unpleasant past events. Therapy can bring up memories or realizations that may be distressing, and some people may experience unanticipated personal dilemmas, worries, or dreams. Also, trying to resolve issues with other important people in your life, such as a spouse/partner, child, or other family member, can lead to discomfort and may result in changes that were not originally intended (such as

separation or divorce, staying in a relationship that you thought you would leave, being asked to see a psychiatrist for a medication evaluation, being asked to attend a self-help or support group, etc.). Similarly, clients who request evaluations for court purposes may discover that our clinical impressions and opinions differ from what they expected. Like any professional or medical service, psychotherapy may not work, and for some people, symptoms or problems may get worse. In general, however, the discomfort experienced in psychotherapy is part of the process of delving into uncomfortable feelings or problems so that you might emerge at a more satisfying and rewarding place.

Choosing the Right Therapist for You. It is very important that you feel comfortable with your therapist and confident in his/her approach. Because of the substantial personal and emotionally investment, time, and finances associated with quality therapy, it is important that you let your therapist know about any concerns you may have. Prior to beginning and at any time during your participation in services from this office, please feel free to ask pertinent questions about our backgrounds, training, and experience, our impressions about your situation, and what treatments may be used inside or outside of this office, including alternative treatments and how to access them. If you feel that another therapist might be better able to help you, please discuss this with us as we are happy to recommend or explore reputable referrals in your area.

5. Notice of Privacy Practices

Please refer to our Notice of Privacy Practices for additional important information.

6. Contact Us

You may reach us in the following ways:

- Mailing Address: 1151 Dove Street, Suite 204 • Newport Beach, CA 92660
- Phone: David NeeSmith, Ph.D. (949) 263-8885, ext. 1
  Michael Toppen, M.A. (949) 263-8885, ext. 3
- Fax (949) 263-8877
- Online: www.DavidNeeSmith.com

7. Special Circumstances

Any special circumstances should be outlined below:

8. Signatures

It is important that you review this service agreement carefully and have a clear understanding of the policies and procedures of this office. Please ask any questions you have and discuss them with Dr. NeeSmith & Associates prior to beginning services.

Please circle if you would like a copy of this service contract. YES / NO

"NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT."

By signing below, I indicate that I understand and agree to comply with the policies and agreements of this office as outlined in this service agreement.

Names of all persons participating in services (Please print):	SIGNATURES:	DATE:

Thank you for your time and for seeking services from our office.
We look forward to serving you!

Office of David NeeSmith, Ph.D. & Associates

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

David NeeSmith, Ph.D. & Associates is required by law to maintain the privacy and confidentiality of your protected health information and to provide you with the notice of our legal duties and privacy practices with respect to your protected health information.

Our Responsibilities under HIPAA

In the course of providing health care, we generate, collect, and share health-related information pertaining to our clients. Traditionally, that information was kept confidential by ethical traditions and a patchwork of regulations that vary by state. Effective April 14th, 2003, we have certain responsibilities regarding that information due to Congressional enactment of **HIPAA**, the ***Health Insurance Portability and Accountability Act***. Most state regulations, which afford you greater privileges or additional rights than those prescribed by HIPAA, still remain in effect.

HIPAA regulations set uniform national standards for anyone receiving, handling, and safeguarding a person's *individually identifiable health information*. 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 is considered **"Protected Health Information" (PHI)** under HIPAA. As part of our normal business operations, we encounter your PHI as a result of your treatment, our billing and payment, and other related health care operations. We also receive your PHI via the application and enrollment process, from healthcare providers and health plans, and by a variety of other activities.

Just as we need to inform you of the benefits and risks of psychotherapy and get your written consent for treatment, HIPAA requires us to provide you with a written Notice of Privacy Practices, hereafter referred to as NOTICE, and then ask for your written acknowledgement of your receiving the NOTICE *before we can use or disclose your PHI in the course of treating you (except in cases of a medical emergency)*. This NOTICE must explain to you how we use and disclose medical information about you and inform you of your rights to access and control that information.

On the following pages, this NOTICE explains our current policies effective on the date specified at the end of this document. We are bound to the provisions of this NOTICE until they are revised and republished. We will display the most current NOTICE in our office and have available current paper copies. It will also be included on all public websites that we may maintain. We reserve the right to revise these policies at any time, as the law requires or permits, and the right to apply those changes to any PHI gathered prior to the policy changes.

HIPAA gives you specific rights of control and access to your PHI. Our responsibilities include assigning a *privacy administrator* to assist you with your rights under HIPAA. At any time, you may contact the administrator to request access to your medical records, give written instructions about your PHI, obtain the current version of this NOTICE, file a complaint, or ask questions about privacy issues that you may have.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations.

In accordance with the HIPAA Privacy Rule, we may use and/or disclose your PHI for a variety of reasons. Generally, we are permitted to use and/or disclose your PHI for the purposes of treatment, payment for services you receive, normal health care operations, and other uses permitted or required by law. For most other uses and/or disclosures of your PHI, you will be asked to grant your permission via a signed authorization. However, the Privacy Rule provides that we are permitted to make certain other specified uses and/or disclosures of your PHI without your authorization. The following are examples of the types of uses and disclosures of your PHI that might occur. Some are more likely to occur than others; some may never happen. These examples are neither exhaustive nor an indication of what we intend to do. They are simply examples of the types of uses and disclosures that could be made by our practice without your permission as allowed by HIPAA.

Treatment
We may use and/or disclose your PHI with psychologists, psychiatrists, physicians, nurses, and other health care personnel involved in providing health care services to you. For example, your PHI may be shared with your primary care physician, medical specialists, members of your treatment team, mental health service providers to whom your are referred, and other similarly situated health care personnel involved in your treatment.

Payment
We may use and/or disclose your PHI for billing and collection activities and related data processing; for actions by a health plan or an insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and the provision of benefits under its health plan insurance agreement; to make determinations of eligibility or coverage, adjudication or the subrogation of health benefit claims; for medical necessity and appropriateness of care reviews, utilization review activities; and related payment activities so that individuals involved in delivering health services to you may be properly compensated for the services they have provided.

Health Care Operations
We may use and/or disclose your PHI in the course of operating the various business functions of our office. For example, we may use and/or disclose your PHI to evaluate the quality of mental health services provided to you; develop clinical guidelines; contact you with information about treatment alternatives or communications in connection with your case management or care coordination; to review the qualifications and training of health care professionals; for medical review, legal services, and auditing functions; and for general administrative activities such as customer service and data analysis.

Appointment Reminders
Unless you request that we contact you by other means, the Privacy Rule permits us to contact you regarding appointment reminders and other similar materials to you.

> *"As a courtesy to our clients, we may call your home, work, or cell phone, or we may email you, the day before your scheduled appointment to remind you of the appointment time. If you do now answer, we may leave a reminder message on your answering machine or with the person who answers the phone. No PHI will be disclosed during this conversation or message other than the date and time of your scheduled appointment and a request to call our office if you need to cancel or reschedule your appointment."*

II. Uses and Disclosures Requiring your Authorization.

Generally, our use and/or disclosure of your PHI for any purpose that falls outside of the definitions of treatment, payment, and health care operations identified above will require your signed Authorization. The Privacy Rule grants us permission for certain specified uses and/or disclosures of your PHI that fall outside of the treatment, payment, and health care operations definitions as itemized below. However, for all other uses and/or disclosures of your PHI by any other person or entity, you retain the power to grant your permission via your signed Authorization. Additionally, if you grant your permission for such use and/or disclosure of your PHI, you retain the right to revoke your Authorization at any time except to the extent that we have already undertaken an action in reliance upon your Authorization. In those instances when we are asked for information for purposes outside of treatment and payment operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes we make about our conversations during private, group, conjoint, or family counseling sessions which we keep separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization, or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures that Do Not Require your Consent or Authorization.

We may use and/or disclosure PHI without your consent or authorization in the following circumstances:

- *Child Abuse*. We may disclose your PHI if disclosure is compelled by the California Child Abuse and Reporting Act. For example, if we, in our professional capacity, observe or have reason to suspect that a child has been injured as a result of physical, mental, or emotional abuse, neglect, sexual abuse, or exposure to domestic violence, we must immediately report this information to a police or sheriff's department or social service or protective service agency. Also, if we have knowledge of or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, we may report this information to the above agencies.
- *Adult and Domestic Abuse*. We may disclose your PHI if disclosure is compelled by the California Elder/Dependent Adult Abuse Reporting Law. For example, if we have reasonable cause to believe that an adult has been or is being abused, abandoned, abducted, isolated, neglected, financially exploited, or is need of protective services, we must report this belief to the appropriate authorities as permitted or required by law.
- *Health Oversight Activities*. We may use and/or disclose your PHI to the California Board of Psychology, California Board of Behavioral Science Examiners, or other oversight agency if necessary for a proceeding before these boards. We may also use and or disclose your PHI in designated activities and functions including audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions.
- *Judicial and Administrative Proceedings*. We may use and/or disclose your PHI in response to an order of a court or administrative tribunal, a warrant, subpoena duces tecum, discovery request, or other lawful process. If you are involved in a court proceeding and a request is made about the professional services that we have provided you, we must not release your information without 1) your written authorization or the authorization of your attorney or personal representative; 2) a court order; or 3) a subpoena duces tecum (a subpoena to produce records) where the party seeking your records provides us with a showing that you or your attorney have been served with a copy of the subpoena, affidavit and the appropriate notice, and you have not notified us that you are bringing a motion in the court to quash (block) or modify the subpoena. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered.
- *Relating to Decedents*. We may use and/or disclose your PHI if compelled or permitted, in the event of your death, to the coroner or medical examiner.
- *Appointment Reminders*. As indicated above, we are permitted to contact you without your prior authorization to provide appointment reminders. Be sure to let us know where and by what means (e.g., telephone, letter, mail, fax) you prefer to be contacted.

- *Marketing*. We may contact you to provide you with information about alternative treatments or other health-related benefits and services that may be of interest to you. For example, we may at times provide clients with information about workshops, services, or resources that we recommend or that may be of interest. It is not our policy to disclose any psychological personal health information for the purpose of notifying you about such activities and resources. Be sure to let us know where and by what means (e.g., telephone, letter, mail, fax) you prefer to be contacted.
- *Research*. In certain circumstances, and under the supervision of an Internal Review Board, we may disclose your PHI to assist in medical/psychiatric research.
- *To Avert a Serious Threat to Health or Safety*. If we believe that there is a substantial likelihood that you have threatened an identifiable person or persons and that you are likely to act on that threat, or if we believe that you present an imminent risk of serious physical harm or death to yourself, we may use and/or disclose your PHI in order to avert a serious threat to health or safety.
- *Worker's Compensation*. We may disclose your health information as necessary to comply with State Workers' Compensation Laws.
- *Emergencies*. We may disclose your health information to notify or assist in notifying a family member, relative, or another person responsible for your care about your psychological or medical condition or in the event of an emergency or of your death.
- *U.S. Secretary of Health and Human Services*. We may disclose your PHI to the U.S. Secretary of Health and Human Services or the Office of Civil Rights if compelled to participate in an investigation or determination of our compliance with privacy, security, and transaction requirements under federal regulations.
- *For Specific Government Functions*. We may disclose your health information for military, national security, prisoner, and government benefit purposes. For example, we may use and/or disclose the PHI of military personnel and veterans in certain situations. Similarly, we may disclose the PHI of inmates to correctional facilities in certain situations. We may also disclose your PHI to governmental programs responsible for providing public health benefits and for workers' compensation. Additionally, we may disclose your PHI, if required, for national security reasons.
- *When Required by Law*. We may use and/or disclose your PHI in other circumstances not described above when law specifically requires that we disclose this information.

IV. Your Rights Regarding Your Protected Health Information (PHI).

The HIPAA Privacy Rule grants you each of the following individual rights:

- *Right to Receive Confidential Communication by Alternative Means and at Alternative Locations*. You have the right to choose how we send your PHI to you. It is your right to ask that your PHI be sent to you at an alternate address or by an alternate method (e.g., email). For example, you may not want a family member to know that you are receiving services from our office. On your request, we will send your bills to another address. We are obliged to agree to your request providing that we can give you the PHI in the format you requested without undue inconvenience.
- *The Right to View and Obtain Copies of Your PHI*. You have the right to view or obtain a copy of your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. On your request, we will discuss with you the details of the request and approval/denial processes. You will receive a response from us within 30 days of our receiving your written request. Under certain circumstances, we may deny your request. If your request is denied, you will be given in writing the reasons for the denial. We will also explain your right to have our denial reviewed. If you ask for copies of your PHI, we will charge you an Administrative Fee of $4 per quarter hour plus not more than 10 cents per page. We may opt to provide you with a summary or explanation of the PHI at a prorated report writing fee, but only if you agree in advance.
- *Right to Request Restrictions*. You have the right to request limits on certain uses and disclosures of your PHI. You have the right to ask that we limit how we use and disclose your PHI for the purpose of treatment, payment, or healthcare operations. If we agree to your request, we will put those limits in writing and abide by them except in emergency situations. However, we are not legally required to agree to restrictions you may request. If we believe it to be in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional. Additionally, you do not have the right to limit the uses and disclosures that we are legally required or permitted to make.
- *Right to an Accounting*. You have the right to receive a list, or accounting, of the disclosures of your PHI we have made. The list will not include uses or disclosures to which you have already consented, those for treatment, payment, or health care operations, those sent directly to you or to your family, those made for law enforcement, corrections, or national security purposes, or those disclosures made before April 15th, 2003. After April 15th, 2003, disclosure records will be held for six years. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we provide to you will include disclosures made in the previous six years (the first six-year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no cost, unless you make more than one request in the same year, in which case we will charge you a reasonable sum based on a set fee for each additional request.
- *Right to Amend*. You have the right to request an amendment of your PHI for as long as the information is maintained in the record. 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 we 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 our receipt of your request. We may deny your request in writing if we find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of our records, or (d) written by a party outside of this office. Our denial will be in writing and will 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 our denial be attached to any future disclosures of your PHI. If we approve your request, we will make the change(s) to your PHI. Additionally, we will tell you that the changes have been made, and we will advise all others who need to know about the change(s) to your PHI. On your request, we will discuss with you the details of the amendment process.
- *Right to a Paper Copy*. You have the right to obtain a paper copy of this notice upon request, even if you have agreed to receive the notice electronically. You may also request to receive a copy of this notice electronically.

V. Psychotherapist's Duties.

As mental health care providers, we are charged with the following duties under HIPAA:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will notify you by mail or upon your first office visit after our revised policies and procedures are enacted. Additionally, you may always view our current Notice of Privacy Practices by viewing our website.

Questions and Complaints.

If you have questions about this notice, disagree with a decision made about access to your records, or have other concerns about your privacy rights, you may contact **David NeeSmith, Ph.D. at 949.263.8885**.

If you believe that we may have violated your individual privacy rights, or if you object to a decision we made about access to your PHI, you are entitled to file a complaint by submitting a written complaint to **David NeeSmith, Ph.D., 1151 Dove Street, Suite 204, Newport Beach, CA 92660.** Your written complaint must name the person or entity that is the subject of your complaint and describe the acts and/or omissions you believe to be in violation of the Privacy Rule or the provisions outlined in this Notice of Privacy Practices.

If you prefer or are unsatisfied with the manner in which this office handles your complaint, you may file your written complaint with the Secretary of the U.S. Department of Health and Human Services (Secretary):

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201.

Any complaint you file must be received by us or filed with the Secretary within 180 days of when you knew, or should have known, the suspected act or omission occurred. We will take no retaliatory action against you if you make such complaints.

Effective Date: This NOTICE is effective April 14th, 2003.

Consent and Authorization.

The Health Insurance Portability and Accountability Act (HIPAA) is a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information. HIPAA allows health service providers to disclose Protected Health Information (PHI) from your records in order to provide you with treatment services, obtain payment for these services, and perform other professional activities known as "health care operations." HIPAA requires that we provide you with our Notice of Privacy Practices and obtain your authorization and consent to use and disclose your protected health information for the purposes of treatment, payment, and health care operations as described in the Notice of Privacy Practices.

We need your consent in order to provide you with health care services in accordance with our Notice of Privacy Practices. You have the right to review our Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we revise our privacy practices, we will notify you by mail or upon your first office visit after our revised policies and procedures are enacted. We always have our Notice of Privacy Practices posted in the office, and you may request a copy at any time. Additionally, you may view our current Notice of Privacy Practices on our website.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for your treatment, payment, or health care operations. However, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by submitting a written request for revocation of this consent and authorization **David NeeSmith, Ph.D. at 1151 Dove Street, Suite 204, Newport Beach, CA 92660**. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary and you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted or we may terminate health care services and refer you to another service provider if the consent is later revoked.

By way of my signature, I provide David NeeSmith, Ph.D. & Associates with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment, and health care operations as described in this Notice of Privacy Practices.

Signature	Date
Signature	Date