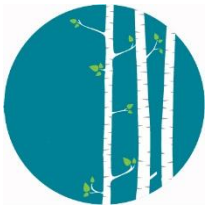

Lisa Porisch Counseling
3421 West Main Street
Rapid City, SD 57702

DATE: _____

Child/Adolescent Registration Packet

Are you a returning client? YES NO If yes, what was your last name when you were last seen here? _____

CLIENT'S LEGAL NAME: _____**PREFERRED NAME:** _____

ADDRESS: _____

PHONE: Home- (_____) _____ Work- (_____) _____ Cell- (_____) _____

MOTHER'S NAME:_____ **FATHER'S NAME:**_____

MOTHER'S OCCUPATION:_____**FATHER'S OCCUPATION:**_____

EMAIL ADDRESS: _____

BEST NUMBER FOR APPOINTMENT REMINDERS: (_____) _____ _____CALL OR _____TEXT

Others that may be contacted for scheduling: NAME: _____Phone: (_____) _____

NAME: _____Phone: (_____) _____

GENDER:_____ **BIRTHDATE:** _____/_____/_____ **AGE:** _____ **SS#:** _____-_____-_____

REFERRED BY: _____ **PRIMARY CARE PHYSICIAN:** _____

PAST THERAPY/TREATMENT (Name, approximate dates): _____

SCHOOL: _____

GRADE:_____

PEOPLE LIVING IN HOME:

NAME	AGE	RELATIONSHIP
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

PRIMARY INSURANCE

Carrier: _____

Policy Holder: _____

Policy Holder's DOB: _____/_____/_____

Relationship to Client: _____

Policy #: _____

Group #: _____

Policy Holder's SS#: _____-_____-_____

SECONDARY INSURANCE

Carrier: _____

Policy Holder: _____

Policy Holder's DOB: _____/_____/_____

Relationship to Client: _____

Policy #: _____

Group #: _____

Policy Holder's SS #: _____-_____-_____

PAYMENT DUE AT TIME OF SERVICE: Payment for your portion of charges is due at the time of service unless other arrangements with the provider have been made. Appointments must be canceled at least 24 hours in advance or you may be billed for missed or late canceled appointments.

- ✔ **Please initial here to acknowledge you've been made aware of this policy: _____**
- ✔ **Who is responsible for payment of this account?: _____**
- ✔ **If our biller would need to contact you, what is the best name and number to reach? Is it ok to leave messages? Yes_____ No_____**

NAME: _____ **PHONE:** (_____) _____

If you have any questions about psychotherapy or our office policies, please ask before signing below. Your signature indicates that you have read our office policies and that you seek and agree to enter mental health services under those conditions. You understand that no promises have been made regarding results of any treatment or procedure provided by the provider. Further, it indicates your understanding that Lisa Porisch Counseling may terminate services if there is a lack of compliance with these policies or if the provider believes you are not benefiting from treatment.

CONSENTS

1. **Consent for Evaluation and Treatment:** Consent is given for evaluation and treatment with Lisa Porisch, LPC-MH. I understand that at times cases are staffed anonymously between the professional staff; I consent to this procedure. It is agreed that either the provider or I may discontinue evaluation, consultation, and/or treatment at any time and that the client is free to accept or reject the services offered or provided.
2. **Assignment of Insurance Benefits/Payment Agreements:** Lisa Porisch's billers will file all insurance claims unless otherwise directed. If the client or responsible party is entitled to insurance benefits of any type arising from any policy which insures the client or other liable person, those benefits are hereby assigned to the provider for credit toward balances on the client account. The client and/or responsible party shall be financially responsible for any charges not paid by insurance. If payment is not made directly to the provider by insurance, payment, in full, is due from the client and/or responsible party. The undersigned agrees to pay the provider the assessed charges, in full, at time of service unless other arrangements have been authorized. Please note, there will be a $45.00 fee on all NSF checks. Lisa Porisch reserves the right to charge 1.5% interest and/or late fees on statements for accounts 60 days past due and not paid in a timely manner. It is the clients' and/or responsible parties' responsibility to set up a payment plan if they cannot pay their statement in full. If client's account is past due, records release may be postponed until payment is made on account.
   Note to Separated/Divorced Parents: *Lisa Porisch will NOT bill the other parent unless that parent coordinates with us. It is your responsibility to seek any reimbursement from the other parent. If your child is a client, you are requested to inform the other parent that your child is receiving services at Lisa Porisch Counseling..*
3. **Release of Information for Medical Insurance Coverage to Insurance, or Managed Care:** To process and determine benefits payable, I hereby authorize my provider to release any necessary part of the client's record, as specified by the Notice of Privacy Practices, to any insurance carrier or entitlement program, which may be obligated to pay all or part of treatment charges. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall remain in effect and valid until this office receives a written revocation signed by the client or other authorized person. I certify that the information I have furnished is true and correct. Personal checks, that identify you, will be presented for deposit at your provider's financial institution.
4. **Consent for the use of Email and Texts:** Lisa Porisch Counseling cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text communications. By signing below the client and/or responsible party is acknowledging and consenting to receive non-encrypted email and text communications.
5. **Notice of Privacy Practices:** I acknowledge that I have received the Notice of Privacy Practices from Lisa Porisch Counseling.
6. **Consent for the use of Ivy Pay for HIPAA compliant credit card processing.**
7. **Consent for telehealth counseling sessions**.

_____ _____

SIGNATURE OF CLIENT OR RESPONSIBLE PARTY DATE

FOR OFFICE USE ONLY Dx_____

CHILDHOOD AND FAMILY HISTORY FORM

Name: _____ Date: _____
Birth Date: _____ Sex: F M Age: _____ Grade: _____

Why are you seeking help for this child: _____
_____
_____

Mother's name: _____ Home Phone _____
Father's name _____ Work Phone _____
Address _____
_____

(Check if applicable): Single ____Separated____Divorced_____
Age of above child at time of divorce/separation_____
Joint Custody? Yes/No Legal Custody with _____ Physical custody with _____

Please list names of all people living in the home.
Name, Age, Relationship to Child
_____
_____
_____
_____

Medical History and Child's Background

1. What problems did mother have during pregnancy? (Health, Illnesses, Injuries, Medication)
_____
_____

Was pregnancy full-term? Yes / No How many weeks? _____ C-Section?_____ Forceps? ____
Breech presentation?____ Birth weight? _____lbs. _____ozs. Apgar score of _____

2. Newborn Infant Difficulties (check all that apply)

___ Born with cord around neck
___ Had trouble breathing
___ Turned blue (cyanosis)
___ Needed Oxygen
___ Injured during birth
___ Got Yellow (Jaundice)
___ Injured during birth
___ Born with a heart defect
___ Born with other defect(s)
___ Was in the hospital more than 7 days

3. Any other problems with labor or delivery?
_____

Health Conditions - Child	Never	0-1 yrs.	2-5 yrs.	6-10 yrs.	11-15 yrs.	16+
Ear infections						
Meningitis						
Seizures or epilepsy						
High fevers (over 103 F. or 39 C.)						
Head injury						
Trouble with ears or hearing						
Trouble with eyes or seeing						
Surgery						
Hospitalizations						
Heart problems						
Lead poisoning						
Allergies to food						
Allergies to environment						
Anemia						
Poisoning or overdose						
Diabetes (since when)						
Asthma (since when)						
Pneumonia						

4. Child's Physician _____ Telephone _____

Is your child currently on any medication? No Yes Please list medication(s) and reason.

_____

5. Please give any *important* medical information, injuries and reasons for hospitalizations or surgery:

_____

_____

_____

6. Please share if your child had any prolonged illnesses. If they had to take medication over along period of time, what was the medication and were there any side effects?:

_____

_____

7. Has your child ever had a neurological exam? No Yes If yes please give information.
Neurologist_____ Date _____ Reason _____

8. Do you have any other concerns about your child's health?

_____

_____

Allergies

9. Allergy to medicines? If yes, describe. _____

10. Allergies to foods. If yes, describe. _____

_____

Developmental Milestones: Please list ages at which your child first:

Sat unaided _____, Crawled _____ Walked independently _____,
Spoke single words (other than mama and dada) _____, Talked using 2-3 words _____,
Was toilet trained _____ (daytime), Toilet trained _____(at night)

11. Please list any difficulties or delays that have occurred in your child's infant years:

_____

_____

Functional Conditions in Early Life (check all that apply to show when condition began or existed)	Never	0-1 yrs.	2-5 yrs.	6-10 yrs.
Sleeping Problems				
Crying often and easily				
Clingy				
Possessive with parents				
Head Banging				
Thumb sucking				
Nail biting				
Rocks back and forth				
Has tics/twitches				
Accident prone				
Temper Tantrums				
Overactivity –seems to always be moving				
Irritability				
Self-destructive behavior				
Extreme reactions to noise or sudden movement				
Tactile sensitivity (bothered by tags or other materials)				
Tendency to make odd sounds, grunts or snorts				
Tendency to twitch or jerk arms or head				
Trouble getting along with peers				
Trouble listening to authority and following rules				
Seems to zone out				
Low self image or esteem (negative self-talk)				
Eating difficulties				
Eats odd things (non-nutritive)				
Wetting or soiling problems				

Coordination	Good	Average	Poor
Walking			
Running			
Balancing			
Throwing			
Catching			
Shoelace tying			
Buttoning			

Temperament

Please indicate whether your child exhibits any of the following behaviors.

Is easily overstimulated in play	No	Yes	_____
Seems overly energetic in play	No	Yes	_____
Has a short attention span	No	Yes	_____
Seems Impulsive	No	Yes	_____
Lacks self-control	No	Yes	_____
Overreacts to problems	No	Yes	_____
Seems unhappy most of the time	No	Yes	_____
Withholds affection	No	Yes	_____
Uncomfortable meeting new people	No	Yes	_____
Hides feelings	No	Yes	_____
Has trouble with changes	No	Yes	_____
Cannot calm down	No	Yes	_____
Requires lots of attention	No	Yes	_____
Has fears	No	Yes	_____

11. What does your child do when he/she is stressed, angry or frustrated? _____
_____

12. How does your child express his/her sadness? _____
_____

Behavioral Symptoms -- Attention / Inattention (check all that currently apply)	Not at All	Just A Little	Quite A Bit	Very Much
Fails to give close attention to details, makes careless mistakes				
Has difficulty maintaining attention in tasks or play activities				
Does not seem to listen when spoken to directly				
Does not follow through on instructions and fails to finish work				
Has difficulty organizing tasks and activities				
Avoids or reluctantly engages in tasks requiring sustained mental effort				
Loses things necessary for activities				
Is distracted by things around him/her				
Is forgetful in daily activities				
Difficulty maintaining alertness, listening to requests, executing decisions				
Fidgets with hands or feet or squirms in seat				
Leaves seat in classroom in which remaining seated is expected				
Runs about or climbs excessively in situations when it is inappropriate				
Has difficulty playing or engaging in activities quietly				
Is "on the go" or often acts as if "driven by a motor"				
Talks excessively				
Blurts out answers before questions have been completed				
Has difficulty awaiting turn				
Interrupts or intrudes on others				
Has difficulty sitting still, being quiet or resisting impulses				
Seems to look around or stare a lot, daydreams				

Behavioral Symptoms (additional)	Not at All	Just A Little	Quite A Bit	Very Much
Depressed mood or irritable mood most of the day				
Persistent fear of social or performance situations				
Decrease in pleasure in activities (things are less fun)				
Excessive fear of specific objects or situations				
Decrease or an increase in appetite				
Excessive or persistent worry about a parent or caregiver				
Difficulty sleeping or seems to sleep a lot				
Reluctance or refusal to go to school				
Fatigue or loss of energy (tires easily or seems tired often)				
Excessive need for reassurance				
Feelings of worthlessness , down on himself/herself				
Concerns about their competence or ability				
Loss of ability to concentrate				
Inability to relax				
Reluctance to be alone, wants parent or caregiver around				
Complains of aches and pains				
Feels hopeless, may wish he/she was dead				
Unusual fears or aversions				

School Concerns and Relationships

13. Did your child attend a preschool/nursery school? If yes, were there any difficulties with your child's behavior? Please share briefly:

_____

_____

14. Has your child experienced learning or academic problems? Yes / No If yes, please describe:

_____

_____

15. Was your child ever retained? If yes what grade?

_____

16. Does your child have difficulty with doing homework/daily work, taking tests, etc.?

_____

17. Has your child ever been evaluated/tested? Yes / No If so, when and where?

_____

18. Have special education services been provided in the past? Yes / No If yes, describe:

_____

19. Describe any *academic* problems reported by teachers: _____

_____

20. Describe any *behavior* problems reported by teachers:

_____

Early Educational Experience	Did Well	Some Problems	Serious Problems	Cannot Say
Learning to read in 1st, 2nd grade				
Reading level in 3rd – 6th grade				
Learning to spell in 1st, 2nd grade				
Spelling in 3rd – 6th grade				
Spelling in 4th – 6th grade				
Learning mathematics 1st – 3rd grade				
Learning mathematics 4th – 6th grade				
Writing words and sentences				
Understanding spoken directions				
Understanding written directions				
Getting homework done in school				
Paying attention in the classroom				
Getting along with other children				
Poor memory				

Communication - Speech

21. Does your child have any *speech or language* problems? Yes/No If yes, when was the problem first noticed? _____ Have there been any previous speech/language services? Yes / No If yes, when and where?

_____

22. Are there any other concerns or relevant information <u>in relation to school</u> that you wish to share and would assist us in meeting your child's needs?

_____

_____

Family History / Health

Concern (please circle)	Child's Father	Child's Mother	Child's Brother(s)	Child's Sister(s)	Others: (specify)
Alcohol/Drug difficulties					
Nervousness					
Seizures or Epilepsy					
Tourettes Syndrome					
Migraine headaches					
Depression					
Anxiety or nervousness					
Emotional disturbance					
Behavior disorder					
Mood Disorder					
Reading problems					
Math problems					
Learning disability					
Speech difficulties					
Hyperactive					
Attention difficulties					

23. Are there any other family concerns or information <u>in relation to your family</u> that you to share and may assist us in meeting your child's needs?

_____

_____

_____

Home Behavior

22. Types of discipline you use with your child? _____

_____

23. What form of discipline do you find to be most effective? _____

_____

24. What are your child's main hobbies and interests? _____

_____

25. What does your child enjoy doing the most? _____

_____

26. What do you see as your child's strengths, abilities, talents ? _____

_____

Other Professionals

25. Has your child ever had psychological counseling or therapy? No Yes
Counselor's name _____ Reason for counseling _____

_____

Client Email/Texting Informed Consent

Email and text messages can be a convenient, preferred and requested form of communication between clients/responsible parties and providers. However, such communication creates risks to your confidentiality. We want you to be aware of the risks and make an informed decision regarding these forms of communication.

1. Risk of Using Email and Text Communication
   The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to the following risks:
   - Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   - Email and text sender can easily misaddress an email or text and send to information to an undesired recipient.
   - Backup copies of emails and texts may exist even after the sender and/or recipient has deleted his or her copy.
   - Employers and online services have a right to inspect emails sent through their company systems.
   - Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
   - Emails and texts can be used as evidence in court.
   - Emails and texts should be assumed to be unencrypted and therefore it is possible that the confidentiality of such communications may be breached by a third party.
2. Conditions for the Use of Email and Text Communication
   Lisa Porisch Counseling cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Lisa Porisch Counseling is not liable for improper disclosure of confidential information that is not caused by intentional misconduct. Client/responsible parties must acknowledge and consent to the following conditions:
   - Email and texting is not appropriate for urgent or emergency situations. The provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
   - Emails and texts should be concise. The client/responsible party should schedule an appointment to discuss complex and/or sensitive situations.
   - Emails may be printed and filed into the client's medical record. Texts may be printed and filed as well.
   - Provider will not forward client's/responsible party's identifiable mails and /or texts without the client's/responsible party's written consent, except as authorized by the law.
   - Clients/responsible parties should not use email or texts for communication of sensitive personal information.
   - Provider is not liable for breaches of confidentiality caused by the client/responsible party or any third party.
3. Client Acknowledgement and Agreement
   I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication using email and/or texts between Lisa Porisch Counseling and me, and consent to the conditions as outlines, as well as any other instructions that may be imposed to communicate with me by email or text.

<u>Please fill out completely</u>
Client Name _____
Email Address _____
Cell Number 1 _____Cell Number 2_____
Client/responsible party if responsible for updating the information on this form if it changes.

_____ _____
Signature of Client/Responsible Party Date

_____
Printed Name Client/Responsible Party

Client-Informed Consent for Online Counseling Services

I, _____ ,(parent/guardian name) hereby consent to engage in online counseling/teletherapy services for my child,_____ ,with Lisa Porisch, LPC-MH. I understand that online counseling/teletherapy includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that online counseling/teletherapy also involves the communication of my medical/mental information, both orally and visually.

I understand that I have the following rights with respect to online counseling/teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. The laws that protect the confidentiality of my medical information also apply to online counseling/teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are limits and exceptions to confidentiality with teletherapy, just as there are with in-person therapy. I am in agreement with these limits/exceptions, and understand that my therapist will explain these to me in detail if I wish.

3. I understand that there are risks and consequences from online counseling/teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of Lisa Porisch, LPC-MH that: the transmission of my information could be disrupted or distorted by technical failures.
** I understand that if the teletherapy session disconnects, Lisa Porisch, LPC-MH will call me back by phone, to complete our session.

4. In addition, I understand that online counseling/teletherapy based services and care may not be as complete as face-to-face services. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not be improve, and in some cases may even get worse.

5. I understand that I may benefit from online counseling/teletherapy, but that results cannot be guaranteed or assured.

6. I accept that online counseling/teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911; or proceed to the nearest hospital emergency room for help; or call my primary care physician or psychiatrist. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.

7. I understand that I am responsible for (a) providing the necessary computer, telecommunications equipment and internet access for my online counseling/teletherapy sessions, (b) using www.doxy.me.com, and (c) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my online counseling/teletherapy session.

I have read, understand and agree to the information provided above.

_____ _____ _____

Parent/Guardian Printed Name Parent/Guardian Signature Date

CREDIT CARD PAYMENT

I understand Lisa Porisch Counseling will bill my insurance company for therapy or assessment services. I understand I am responsible for all reasonable and customary fees that my insurance company does not pay, such as deductibles or co-pays. I understand Lisa Porisch Counseling bills my insurance company as a courtesy to me rather than my paying for services up front and waiting to be reimbursed by my insurance company. I understand Lisa Porisch Counseling will work with me and my insurance company to receive payment from them.

For my convenience, Lisa Porisch Counseling will wait a reasonable amount of time to be reimbursed by my insurance carrier for services delivered. However, sometimes insurance companies do not pay in a timely manner and they do not reimburse at the rate that was initially expected. Because of this, I am giving Lisa Porisch Counseling permission to charge my credit card for any services that have not been paid by myself or my insurance carrier within thirty (30) days of billing.

I also understand that I may elect to have Lisa Porisch Counseling automatically charge my credit card for the balance due. I may also make special payment arrangements and elect to have Lisa Porisch Counseling charge my credit card based on this payment arrangement. This will be done if I choose those terms below and if those terms are agreed upon by a Lisa Porisch Counseling representative.

I understand that Lisa Porisch Counseling will charge my credit card using Ivy Pay which is a HIPAA complaint credit card processing service for mental health therapists. Lisa Porisch Counseling follows all HIPAA and Confidentiality standards.

I authorize Lisa Porisch Counseling to automatically withdraw payments on my account. This authorization will remain in effect until I give written notification to terminate the authorization or until my balance is paid in full.

Patient name: _____

Cardholder name (if different from patient): _____

CardholderBilling Address: _____

City: _____ State: _____

Zip Code:_____

Cardholder Phone Number: _____

Credit Card (Visa, Mastercard, Discover, etc): _____

Credit Card Number: _____ /_____ /_____ /_____

CCV Code: _____ Expiration Date: _____ / _____

Terms of payment (check one):

□ Charge the full balance due after thirty (30) days of billing

□ Charge a specific amount to the credit card at each visit (requires Lisa Porisch Counseling approval; Amount: $_____) For example your co-pay with your insurance coverage.

□ Other terms discussed and agreed upon between myself and Lisa Porisch Counseling as outlined below:

_____ _____

Client/guardian signature Date Lisa Porisch Counseling signature Date

OFFICE PROCEDURES

Welcome and thank you for choosing Lisa Porisch Counseling. This statement is to let you know about our policies. Please discuss any questions that you may have with your therapist.

CONFIDENTIALITY – The laws of the State of South Dakota require that most issues discussed during the course of therapy with a psychologist or social worker are confidential. These laws permit you to waive the privilege of confidentiality by signing a release of information form. However, there are instances in which confidential information will be released. By law, the release of confidential information is required in situations of the suspected abuse of others, potential harm to oneself or others, and in instances where the court may subpoena records. We also provide information to insurance companies and entitlement programs when filing for payment with your consent.

CANCELLATION AND MISSED APPOINTMENTS – Cancellations of your appointments are inevitable. However, if you have an appointment that you are unable to keep, please reschedule or cancel the appointment at the earliest opportunity. **You may be charged for all, or a portion of, your appointment if you do not cancel at least 24 hours prior to the appointment time.**

BILLINGS AND INSURANCE – The cost of your first therapy session is $225.00. Additional therapy charges range from $150.00 - $200.00 per session. We accept assignment from Medicaid. Insurance claims are filed as a courtesy to our clients. However, any charges incurred over the course of therapy is your responsibility. Legally, we cannot bill other individuals (including ex-spouses) for your services or any services which you consent to for your child. In such cases, we will bill you and it is your responsibility to get a guarantee of payment or reimbursement from the person who has agreed to pay or has legal responsibility for your bill. If a school district or the court system has contracted with us to provide the services, please provide us with such documentation and we will bill them accordingly.

You are responsible for timely payment of your portion of the bill which is not covered by your insurance if applied to the deductible, a copayment, or a non-covered service. You are responsible for all services provided, even if your insurance may eventually pay for a portion of the services received. The hourly fee includes not only therapy, but can involve printed material, reports, letters, and telephone calls. Lisa Porisch Counseling reserves the right to charge 1.5% interest and/or late fees on statements for accounts 60 days past due and not paid in a timely manner. If you have any questions regarding your billing, please contact us at (605) 468-1865 to be directed to the specific biller who is working with Lisa Porisch.

PAYMENT FOR SERVICES – Payment of your portion of the bill is expected at the time services are provided. Please discuss with your therapist any alternate payment plans you may need to make. Please note there will be a $50 returned check fee on all checks with insufficient funds.

ETHICAL AND PROFESSIONAL STANDARDS – As a counselor licensed by the State of South Dakota, we do our best to uphold the most responsible and ethical standards possible. If you have any questions or concerns about your course of services with us, please discuss these with your therapist.

Lisa Porisch Counseling

Notice of Privacy Practices

This notice describes how psychological information about you may be used and disclosed and how you can get access to this information.

Please review this carefully. The privacy of your health information is important to us.

If you would like a hard copy to take with you, please request one from the receptionist.

Our Legal Duty

Effective Date, Restrictions, and Changes to Privacy Policy

We are required by applicable federal and state law to maintain the privacy of your psychological information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your psychological information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all psychological information we created or reviewed before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice available to our clients at the time of the change.

You may request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses & Disclosures of Psychological Information for Treatment, Payment and Health Care Operations

Our office may use or disclose your protected health information (PHI) for treatment, payment, and health care operation purposes. To help clarify these terms, here are some definitions.

- PHI refers to information in your health/medical record that could identify you. This does not include psychotherapy notes.
- Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when your provider consults with another health care provider, such as your family physician or another psychologist or counselor.
- Payment is when we obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- Health care operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- Use applies only to activities with our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- Disclosure applies to activities outside our office, such as releasing, transferring, or providing access to, information about you to other parties.

Uses and Disclosures Requiring Authorization

Our office may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific

disclosures. In those instances when we are asked for information for purposes outside of treatment, payment, and health care operations, we will obtain an authorization form from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy notes are notes that are made about your conversation during a private, group, joint, or family counseling session with your therapist. 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 and the law provides the insurer the right to contest the claim under the policy.

Uses and Disclosures with Neither Consent nor Authorization

Our office may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If our office has reasonable cause to suspect that a child under the age of eighteen has been abused or neglected, we are required by law to report that information to the state's attorney, the Department of Social Services or law enforcement personnel.
- Health Oversight: if the South Dakota Board of Examiners of Psychologists is conducting an investigation, then we are required to disclose your mental health records upon receipt of a subpoena from the Board.
- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we may not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance, if this is the case.

- Serious Threat to Health or Safety: When we judge that a disclosure of confidential information is necessary to protect against a clear or substantial risk of imminent harm being inflicted by you on yourself or another person, our office may disclose such information to those persons who would address such a problem (for example, the police or the potential victim).
- Workers Compensation: If you file a workers compensation claim, our office is required by law to provide your mental health information relevant to that particular injury, upon demand to you, your employer, the insurer, and the Department of Labor.

Patient's Rights and Provider's Duties

Patient Rights:

- Right to Request Restrictions – you have the right to request restrictions on certain uses and disclosures of protected health information about you. However, our office is not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – you have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing someone in our office. Upon your request we will send your bills to another address.)
- Right to Amend – you have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- Right to an Accounting – you generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- Right to a Paper Copy – you have the right to obtain a paper copy of the notice from our office upon request, even if you have agreed to receive the notice electronically.

Provider's Duties:

- 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 give you a copy of the updated policies and procedures upon your next visit to our office.

Questions and Complaints
If you want more information about our privacy practices or if you are concerned that our office has violated your privacy rights, or you disagree with a decision our office has made about access to your records or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may contact Lisa Porisch, our Privacy Officer. You may also send a written complaint to the Secretary of the US Department of Health and Human Services.