



**CLIENT INFORMATION**

Your Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Client Name (if different) : \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**For Minor Clients:**

*What is your relationship to the minor? (check all that apply)*

Parent  Legal Guardian  Foster Parent  Self  Other, (specify): \_\_\_\_\_

*Do you hold the legal privilege for this minor?*  No  Yes

*If no, who holds the legal privilege for this minor?*

Parent  Legal Guardian  Court  Minor  Other, (specify): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone: \_\_\_\_\_ Alternate: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

School/Employer: \_\_\_\_\_ Grade: \_\_\_\_\_ Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

How were you referred?: \_\_\_\_\_

E-Mail (Optional) \_\_\_\_\_

**Payment Information:**

Name of Insurance Company: \_\_\_\_\_ Telephone: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group ID: \_\_\_\_\_ Plan ID: \_\_\_\_\_

Authorization to see Michael A. Jones, LCSW \_\_\_\_\_ Co-Pay per visit: \_\_\_\_\_

Provided Mental Health Services Information

Provided Grievance and Appeal Procedures

Please list the names of the people who live in your home:

	Name	Age	Their Relationship to you
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

**Briefly, why are you seeking my services at this time ?**

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**Medical History – Yours (client’s), and biological relatives (as far as you know)**

<u>Check all those that apply</u>	<u>Client</u>	<u>Relatives</u>	<u>DESCRIBE (use back page for detail)</u>
Injuries to head			
Thyroid problems			
Diabetes or blood sugar issues			
Sexually transmitted disease			
Fainting/ loss of consciousness			
Allergies			
Physical impairment or handicap			
Menses – difficulties or irregular			Age of onset
Aches/pains (head, stomach, etc.)			
Medical Hospitalization			
Other Diseases			

**Mental Health History - Yours (client’s), and biological relatives (as far as you know)**

<u>Client</u>	<u>Relatives</u>	<u>DESCRIBE</u>
		Depression
		Mania
		Risk Taking Behaviors
		Mental Health Hospitalization
		Therapy or Other Treatment

<b>Current Medications/Dosages:</b> _____
<b>Supplements/Vitamins:</b> _____
<b>Over the Counter Medications:</b> _____
<b>Most recent Medical Exam:</b> _____ <b>Recommendations:</b> _____
<b>Physician's Name:</b> _____ <b>Telephone #:</b> _____

**Previous or Current Mental Health or Other Treatment Providers with Whom to Consult or Collaborate:**

Dates Attended	Name of Provider Address/Telephone	Topics of Treatment	Level of Satisfaction

**Life Stages History – Family History**

In each section, please list the members of the household during that period in your life, and any events or experiences that you feel were significant, or impacted you positively or negatively, including any traumatic events. Please do not feel pressured to write down things that you do not wish to write about.

**Client's mother's pregnancy history** *(If you know anything about the mother's life experiences during her pregnancy, positive or negative, including her health and relationship with the father, please include it here.)*

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**Early Developmental Details** *(ages 0-5 – ex: learning to talk, walk, use the bathroom, etc.)*

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**Childhood** *(ages 6-12)*

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**Adolescence** *(age 12 to 17)*

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**Young Adulthood** *(ages 18 - 22)*

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**Adulthood** *(ages 23 to present)*

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**Educational History**

**Schools Attended**

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**Academic Performance (include special needs)**

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**Friendships/ Peer Relationships in School**

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**Spiritual/Cultural History**

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**Legal History**

(Ex: Arrests, Restraining Orders, Charges, Convictions, Sentences, Jail/Prison, Court Cases, Divorce, Child Custody)

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**Current Symptoms – Please check and describe those which concern you.**

<b>PHYSICAL SYMPTOMS</b>		
Sleeping Patterns		
Appetite		
Weight Change		
Fatigue		
Crying		
Sexual Energy Changes		
Aches and Pains		

<b>MENTAL STATUS</b>		
Hopelessness about the Future		
Decrease of Enjoyment/Interests		
Difficulty Making Decisions		
Ability to Concentrate		
Preoccupation with Death		
Thoughts of Suicide		
Past Suicide Attempts		

<b>THINKING PROCESSES</b>		
Traumatic memories		
Intrusive thoughts		
Flashbacks		
Dwelling or Daydreaming		
Self-blaming thoughts		
Worries interfere with life		
Easily irritated		
Rages		
Fearfulness		
Loneliness or Isolation		
Relationships with Family and Friends		

<b>RISK ASSESSMENT</b>		
Do you intend to hurt anyone?		
Have you identified that person?		
Do you have a plan to hurt that person?		
Do you have a means to hurt that person?		
Do you intend to hurt yourself?		
Do you have a plan to hurt yourself?		
Do you have a means to hurt yourself?		
Have you attempted to hurt yourself?		
Child Abuse in your family		
Relationship Violence in your family		
Disabled Abuse in your family		
Elder Abuse in your family		
Animal Abuse in your family		

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## Alcohol and other Substance Use Screening

### **Part One: Alcohol Screen**

1. Do you drink alcohol?  
*if “no”, go to Part Two*
2. How often do you drink more than 2 drinks on one occasion?  
*if “never”, go to question 4*
3. *(If answer to any of these questions is “yes”, use other alcohol assessments)*
  - a. Have you ever found you were not able to stop drinking once you had started?
  - b. Have you ever failed to do what was expected of you because of drinking, or have you ever felt guilty after drinking?
  - c. Has anyone ever been concerned about your drinking or suggested you drink less?
4. Do you feel you have a problem with drinking?
5. Have you ever sought treatment for drinking?

### **Part Two: Other Substance Screen**

1. For clients who take prescription medication: Do you believe you have a problem with taking too much medication, or has anyone ever been concerned that you have a problem with taking too much?
2. Do you currently use other substances or drugs, legal or illegal, or have a history of using drugs?
3. Have you ever sought treatment for using drugs, medications, or other substances?

*If answers to 1,2 and 3 are “no”, skip the rest of this section and go on to Domestic Violence..*

*If either 1, 2 or 3 is “yes”, fill out the following chart:*

#### **Substance Use Information Chart**

Name of Substance	Date of Last Use	Amount of Last Use	Frequency	Duration	Age of First Use

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## Relationship Violence Screening

Are there any times when you feel frightened in your relationship, current or past?

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Are there any things that your partner has done that have made you feel scared?

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Have you or your partner ever thrown things when angry? Broken things? Punched walls or furniture?

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Has there been any of the following between you and your partner? Mark those that apply and explain.

- Yelling \_\_\_\_\_
- Hitting \_\_\_\_\_
- Swearing \_\_\_\_\_
- Threatening \_\_\_\_\_
- threatening family members/pets \_\_\_\_\_
- threatening financial resources \_\_\_\_\_
- use of weapons \_\_\_\_\_
- following or checking up on \_\_\_\_\_
- controlling decisions \_\_\_\_\_

Has your partner ever hurt him/herself, on purpose, because they were angry at you?

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Have the police ever been involved, because of you or your partner?

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Are you in danger in your relationship?

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Do you have a plan to avoid/escape relationship violence? \_\_\_\_\_

Do you need help developing resources to avoid/escape relationship violence? \_\_\_\_\_

# MICHAEL A. JONES, LCSW

LCS 22452

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(619) 297-0010

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## INFORMED CONSENT and CONFIDENTIALITY AGREEMENT

### Introduction

This agreement is intended to provide \_\_\_\_\_ (*Client*) with important information regarding the practice policies and procedures of Michael A. Jones, LCSW (*Therapist*) and to clarify the terms of the professional therapeutic relationship between Client and Therapist. The Health Insurance Portability and Accountability Act of 1996 (*HIPPA*) requires that Client is provided with a Notice of Privacy Protection which is attached to this agreement. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

### Therapist Education, Training, Experience, Theoretical and Treatment Approaches

Therapist earned a master's degree (*MSW*) and has been licensed by the Board of Behavioral Sciences in California as a clinical social worker (*LCSW*) since December 15, 2004. Therapist participates in a minimum of 18 hours of continuing education every two years. Therapist has experience working with children, adolescents, adults, couples, families, groups and supervisees. Therapist employs treatment modalities based in attachment, developmental, psychodynamic, and cognitive-behavioral theories. In approaches targeting the parent-child relationship therapist may demonstrate, teach, and encourage the use of appropriate safe touch in care, nurturing, and play with children and adolescents. Therapy approaches with children, adolescents, couples and families most often require the participation of all parties in treatment. Therapist employs a time-limited approach based on diagnosis, prognosis, and mutually agreed upon modalities, established treatment goals, and behaviorally measurable progress. Therapist also employs a crisis management model including immediate assessment, referral, and possible ethical, legal, and medical coordination when immediate risk supersedes current treatment.

### Benefits and Risks of Therapy

Psychotherapy is a process in which Client and Therapist explore and discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Client can experience his/her life more fully. Psychotherapy is a joint effort between Client and Therapist. Progress and success may vary depending upon several factors, including but not limited to the types of issues or problems being explored and addressed, Client's personal history, Client's resources and support systems, and Client's level of motivation.

Participating in therapy may result in a number of benefits to Client, including, but not limited to, a reduction in stress, anxiety, and depression, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of Client, including an active participation in the therapeutic process, honesty, and a willingness to change thoughts, feelings, and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, guilt, anger, frustration, fear, loneliness, helplessness, and hopelessness. There may be times in which Therapist will challenge

Client's perceptions and assumptions, and offer different perspectives. The issues presented by Client may result in unintended outcomes, including changes in personal relationships. Client should be aware that any decision on the status of his/her personal relationships is the responsibility of Client.

During the therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Client should address any concerns he/she has regarding his/her progress in therapy with Therapist.

### **Professional Consultation**

Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Client.

### **Records and Record Keeping**

Therapist may take notes during session, and will also produce other notes and records regarding Client's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter normal record keeping process at the request of any Client. Should Client request a copy of Therapist's records; such a request must be made in writing. Therapist reserves the right, under California law, to provide Client with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Therapist will maintain Client's records for ten years following termination of therapy. However, after ten years, Client's records will be destroyed in a manner that preserves Client's confidentiality.

### **Confidentiality**

The information disclosed by Client is generally confidential and will not be released to any third party without written authorization from Client, except when required or permitted by law. Exceptions to confidentiality include, but are not limited to, the *suspected abuse* of children (including by relationship violence), dependent adults, the elderly, and animals. Exceptions to confidentiality also include serious risk of *self injury* including suicide, the use of dangerous substances, and untreated medical conditions that could cause imminent death. Therapist also has a legal duty to warn the identified victim and report to police *intended harm* to persons and property. Therapist will work with Client to facilitate joint report when possible and to maintain the therapeutic relationship while providing only the information necessary to meet legal and ethical mandated reporting requirements.

When parents and children, couples, or families participate in therapy, the parent-child, couple, or family is the treatment unit. Therapist will maintain the confidentiality of each individual but cannot guarantee that all parties in the treatment unit will maintain confidentiality for the others. Therapist may meet with a smaller part of the treatment unit but uses his best clinical judgment to determine whether, when, and how to make disclosures of information learned in the separate session to the rest of the treatment unit, usually encouraging and facilitating the smaller unit to communicate the information to the rest of the treatment unit. If you feel it necessary to talk about matters you do not want to share with the rest of the treatment team, you may consider individual therapy. The addition of other parties to the treatment process will require each individual Client or Client representative to sign an Authorization for the Release of Protected Health Information or a renegotiation of the psychotherapy contract.

## **Client Litigation**

Therapist will not voluntarily participate in any litigation, or custody dispute in which Client and another individual, or entity, are parties. Therapist has a policy of not communicating with Client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Client's legal matters. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Client, Client agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist is available for such an appearance at Therapist's usual and customary hourly rate of **\$120.00**.

## **Psychotherapist-Client Privilege**

The information disclosed by Client, as well as any records created, is subject to the psychotherapist-client privilege. The psychotherapist-client privilege results from the special relationship between Therapist and Client in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. If Therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-client privilege on Client's behalf until instructed, in writing, to do otherwise by Client, Client's representative, or the Court. Client should be aware that he/she might be waiving the psychotherapist-client privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding including those against the Therapist. Client should address concerns he/she might have regarding the psychotherapist-client privilege with an attorney.

## **Fee and Fee Arrangements**

The usual and customary fee for service is **\$120.00** per 45-minute session. Sessions longer than 45-minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Client will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payors, or by agreement with Therapist. Clients are expected to pay for services at the time services are rendered unless other arrangements are made in advance. Therapist accepts cash and personal checks. Client will be charged **\$25.00** if a check is returned from the bank due to insufficient funds. Thereafter, Client will be required to pay by cash only.

From time-to time, Therapist may engage in telephone contact with Client for purposes other than scheduling sessions. Client is responsible for payment of the agreed upon fee at a pro rata basis for any telephone calls longer than ten minutes.

## **Insurance**

Client is responsible for full payment of all fees. If Client intends to use benefits of his/her health insurance policy, this must be agreed upon in advance by Client and Therapist. If Therapist is a contracted provider for the Client's insurance plan, Therapist will submit claims and required paperwork to be reimbursed by the insurance company. Client is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles. Client is responsible to request initial authorization from his/her insurance plan. Client is responsible for payment of co-pays and deductibles at the time of the session. Use of the Client's insurance requires the signed Authorization for Release of Protected Health Information and Notice of Privacy Practices.

If Therapist is **NOT** a contracted provider for the Client's insurance plan, Client will be responsible for full payment at the time of the session. Client will be provided with a statement which Client can submit to his/her insurance company to seek reimbursement for fees already paid. Client agrees to inform Therapist in

advance of any changes related to insurance coverage. Therapist is a contracted provider with several companies and has agreed to specified fees.

### **Cancellation Policy**

Client is responsible for payment of the full fee for any session(s) not cancelled within 24 hours. Cancellation notice should be left on Therapist's voice mail at **(619) 297-0010**. If Client does not call to cancel a session and does not arrive at the scheduled time, Therapist will wait for **15 minutes**. At that time, if Client has not arrived or phoned to report a delay, the session will be considered non-attended and the fee will apply. In the event of a non-cancelled and non-attended session, Client agrees to contact Therapist within seven days to schedule the next session. ***Please note: the same day and session time may not be available.*** If Client does not contact Therapist within seven days of a non-cancelled and non-attended session, Therapist will assume that Client does not wish to continue therapy at that time. Client may contact Therapist to resume therapy if and when desired. When insurance prohibits late fees, Therapist will terminate service and provide referrals after two no show sessions.

### **Therapist Availability**

Therapist's office is equipped with a confidential voice mail system that allows Client to leave a message at any time. Therapist will make every effort to return calls within 24 hour (or by the next business day), but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. ***In the event that Client is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, the Access and Crisis Line at (800) 479-3339, or go to the nearest emergency room.*** Therapist's outgoing message will provide these same instructions. Therapist is routinely in the office Monday through Friday. ***Sessions are by scheduled appointment only.*** Therapist will inform Client of changes to the routine schedule.

### **Termination of Therapy**

Client and Therapist may agree to end therapy when treatment goals are met. Therapist reserves the right to terminate therapy at Therapist's discretion. Reasons for termination include nonattendance, untimely payment, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Client needs are outside the Therapist's scope of competence or practice, or Client is not making adequate progress in therapy. Client has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Client participate in at least one termination session. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work done and make appropriate recommendations. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals and making himself available for continuity of care. Therapist has made provisions for notifying clients, providing referrals, and maintaining client records in the event of Therapist death, disability, or business closure.

**MICHAEL A. JONES, LCSW**

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**Acknowledgement**

By signing below, Client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Client has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Client's satisfaction. Client agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Client agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

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\_\_\_\_\_  
Client Name (please print)

\_\_\_\_\_  
Signature of Client (or authorized representative)

\_\_\_\_\_  
Date

I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payor.

\_\_\_\_\_  
Name of Responsible Party (please print)

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

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The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") was passed by Congress to promote standardization and efficiency in the health care industry. The Privacy Practices below have been required by the U.S. Congress for ALL health care providers. In addition, the U.S.A. Patriot Act passed and renewed by Congress in 2006 has some implications for psychotherapists and their clients.

## Notice of Privacy Practices

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

### **II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)**

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

If I make any changes to my policies, they will only be effective for clients who have consented to the changes. I will also promptly change this Notice and provide a new copy of it in my office at Michael A. Jones, LCSW, 1835 El Cajon Boulevard, Suite A., San Diego, California 92103, 619-297-0010. You can also request a copy of this Notice from me, or you can view a copy of it in my office Michael A. Jones, LCSW, 1835 El Cajon Boulevard, Suite A., San Diego, California 92103, 619-297-0010.

### **III. HOW I MAY USE AND DISCLOSE YOUR PHI.**

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

**A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.** I can use and disclose your PHI without your consent for the following reasons:

1. To Obtain Payment for Treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
2. Patient Incapacitation or Emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

**B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization.** I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state, or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.
2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.
3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.
4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.

5. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.
6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.
7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.
8. To remind you about appointments and to inform you of health-related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

**C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.**

1. Disclosures to Family, Friends, or Others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

**D. Other Uses and Disclosures Require Your Prior Written Authorization.** In any other situation not described in sections III A, B, and C above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

#### **IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI**

You have the following rights with respect to your PHI:

**A. The Right to Request Restrictions on My Uses and Disclosures.** You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.

**B. The Right to Choose How I Send PHI to You.** You have the right to request that I send confidential information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

**C. The Right to Inspect and Receive a Copy of Your PHI.** In most cases, you have the right to inspect and receive a copy of the PHI that I that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

If you request copies of your PHI, I will charge you not more than \$.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

**D. The Right to Receive a List of the Disclosures I Have Made.** You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before April 14, 2003.

I will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I may charge you a reasonable, cost-based fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The Right to Receive a Paper Copy of this Notice. You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

## **V. HOW THE U.S.A. PATRIOT ACT IMPACTS YOUR CONFIDENTIALITY AND PRIVACY**

This new law allows the government to issue warrants to inspect your treatment records without your knowledge including the fact that you have been a client. Further, the law forbids the therapist from informing you that your treatment records have been inspected and imposes the risk of arrest and conviction on therapists who do so. It is our policy to seek legal advice in responding to such warrants or searches in an effort to protect your privacy and confidentiality even if you are not aware of it.

## **VI. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES**

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

## **VIII. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES**

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Michael A. Jones, LCSW, 1835 El Cajon Boulevard, Suite A., San Diego, California 92103, 619-297-0010

## **VIII. EFFECTIVE DATE OF THIS NOTICE**

This notice went into effect on June 1, 2006.

## Acknowledgement of Receipt of Notice of Privacy Practices

Primary Client: \_\_\_\_\_ D.O.B. \_\_\_\_\_

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") was passed by Congress to promote standardization and efficiency in the health care industry. HIPAA will accomplish these goals by imposing new restrictions on how covered entities (such as psychotherapists) can use and share information, and by creating new rights for individuals concerning their health information.

By signing this form, you are acknowledging receipt of the *Notice of Privacy Practices* (the attached packet). The *Notice of Privacy Practices* provides information about how the HIPAA law indicates that I may use and disclose your protected health information.

The *Notice of Privacy Practices* is subject to change. If there are changes made to the privacy practices required of psychotherapists, I will notify you, and you may obtain a copy of the revised notice from me by contacting me at 619-297-0012.

If you have any questions about this *Notice of Privacy Practices*, please contact me at: Michael A. Jones, LCSW, 1835 El Cajon Boulevard, Suite A., San Diego, California 92103, 619-297-0010.

\_\_\_\_\_  
Client/Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

### INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my patient's acknowledgement of his or her receipt of my Notice of Privacy Practices, including \_\_\_\_\_. However, because of \_\_\_\_\_ I was unable to obtain my patient's acknowledgement.

\_\_\_\_\_  
Michael A. Jones, LCSW  
Provider

\_\_\_\_\_  
Date