AR PSYCHIATRIC & COUNSELING CENTER

NEW PATIENT INFORMATION

Patient Name:_____ ❑ Male ❑ Female
First Middle Last

Date of Birth: _____Social Security Number (SSN): _____Marital Status:_____

Street Address: _____
City State Zip Code

Home Phone: _____Cell Phone: _____E-mail Address: _____

Employer: _____Work Phone: _____

Mother's Maiden Name: _____ State You Were Born _____Race:_____

If patient is a minor, do you have legal custody? ❑ Yes ❑ No

If divorced, has either parent had parental rights terminated? ❑ Yes ❑ No

Legal Guardian's Name: _____Relationship to Patient: _____

Legal Guardian's SSN: _____Guardian's Date of Birth: _____

Is patient a full-time student? ❑ Yes ❑ No

Emergency Contact:_____Phone:_____

Emergency Contact Address:_____ Relationship to patient:_____

Insurance Company:_____Policy Holders name :_____(As it appears on the card)

Insurance Address : _____Phone#_____

Policy/Subscriber Number :_____ Group Number:_____

Policy Holders SSN :_____Policy Holders Date of Birth:_____

A COPY OF YOUR DRIVERS LICENSE and INSURANCE CARD IS NEEDED
PAYMENT OF SERVICES IS HANDLED PRIOR TO YOUR SESSION

I request that payment and benefits be made on my behalf to AR Psychiatric & Counseling Center, LLC for any services furnished to me by its physicians or providers. I understand that my signature also authorizes release, if necessary, of any medical, HIV, psychiatric and substance abuse information contained in my records to my insurance or its assignees. I request and authorize treatment at AR Psychiatric & Counseling Center, LLC. I understand I am responsible for any deductible, co-payment or any amount not covered by my insurance. I understand that AR Psychiatric & Counseling Center, LLC, turns delinquent accounts over to a third party collector, and I will be accessed a collection fee of $50.00 dollars. Monthly finance charges may be added to all accounts over 60 days old. A fee of $30.00 dollars will be charged for any returned checks.

_____
Signature of Patient or Legal Guardian Relationship Date

New Patient Information Sheet (Continuation)

Who referred you to our office? _____

Reason for seeking treatment/ main complaints: _____

_____

_____

How long has this been occurring? Days/ Weeks/ months:_____

Are you experiencing any of the following?

- ◻ Depressed mood
- ◻ No Interest in things
- ◻ Tiredness
- ◻ Sleep disturbance
- ◻ Change in appetite
- ◻ Lack of motivation
- ◻ Irritability/ Anger
- ◻ Lack of concentration
- ◻ Indecisiveness
- ◻ Feelings of worthlessness
- ◻ Suicidal thoughts
- ◻ Self-mutilation
- ◻ Excessive worrying
- ◻ Inability to relax
- ◻ Muscle tension
- ◻ Anxiety attacks
- ◻ Nervousness
- ◻ Obsessive thinking
- ◻ Compulsive behaviors
- ◻ Fears or Phobias
- ◻ Paranoia
- ◻ delusional beliefs
- ◻ Hallucinations
- ◻ Bingeing
- ◻ Purging
- ◻ Poor memory
- ◻ Substance use/ Abuse
- ◻ General Stress
- ◻ Grief or Loss
- ◻ General Health Problems
- ◻ relationship problems
- ◻ Stress from work
- ◻ Recent or past severe trauma
- ◻ Sexual/ physical or emotional abuse

If it is a child or adolescent, have you noted any of the followings?

- ◻ Hyperactivity
- ◻ Impulsivity
- ◻ inattentiveness
- ◻ Anger outbursts /irritability
- ◻ Argumentativeness/ Defiance
- ◻ Depression
- ◻ Anxiety
- ◻ Fearfulness
- ◻Temper tantrums
- ◻ Compulsive behaviors
- ◻ Lying
- ◻ Stealing
- ◻ Tics
- ◻ Bingeing
- ◻ Purging
- ◻ Running Away
- ◻ Sexually inappropriate behaviors
- ◻ Gang Involvement
- ◻ Property destruction
- ◻ Fire setting
- ◻ Cruelty to animals
- ◻ Bullying
- ◻ Bed wetting
- ◻ Social withdrawal
- ◻ Bizarre behaviors or thinking
- ◻ Paranoia
- ◻ Hallucinations
- ◻ Peer relationship problems
- ◻ Sibling relationship problems
- ◻ Learning disability
- ◻ Speech/ language difficulties
- ◻ Disciplinary problems

New Patient Information (Continuation)

Previous Treatment: (include substance abuse and psychiatric): ☐ None.

Inpatient: 1. How Many? _____ ☐ None

2. Which Hospitals? _____

_____

Outpatient: _____

Previous provider: _____

Previous psychiatric diagnosis (if known): _____

Previous psychiatric meds used and the response (if known): _____

_____☐ None.

Previous Suicide attempts: ☐ Yes ☐ None Describe: _____

Previous Acts of aggression: ☐ Yes ☐ None Describe: _____

Have any of your family members ever had treatment for a mental or nervous condition before? ☐ Yes ☐ No ☐ Mother ☐ Father ☐ Brother/Sister ☐ Children ☐ Grandparents ☐ Other

If yes, then diagnosis (if known): _____

Do you smoke? ☐ Yes ☐ No How many packs per day? _____

Do you drink alcohol? ☐ Yes ☐ No How many alcoholic drinks do you consume per Week?

_____

Do you do illicit drugs: ☐ Yes ☐ No If yes, explain; _____

Are you involved In an investigation by the Department of Family/Children Services? ☐ Yes ☐ No

Are you involved in any legal actions or lawsuits? ☐ Yes ☐ No

Have you ever been arrested? ☐ Yes ☐ No If yes, then explain; _____

Are you involved In a worker's compensation claim? ☐ Yes ☐ No

Highest level of education achieved: _____

Ever been in military? ☐ Yes ☐ No If yes, then any combat trauma ☐ Yes ☐ No

Interests/ Hobbies: _____

Medical History

Name:	Date of Birth:
Address:	Phone:
Pharmacy Name:	Location:
Phone Number:	Primary Care Physician:

List any allergies:_____

List all Medications (include dosage if know):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

List All Medical Problems:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

List all the surgeries you have had:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

I give my permission for AR Psychiatric & Counseling Center staff to contact my pharmacy with questions regarding my past and present medications. They will be calling for information regarding my ongoing treatment.

_____ _____

Patient or Legal Guardian Signature Date

AR Psychiatric & Counseling Center
3312 D North Oak St. EXT Valdosta, GA
31605
229-244-2030

AR PSYCHIATRIC AND COUNSELING CENTER
General Information

Welcome to the AR Psychiatric and Counseling Center. We are a private mental health facility located at Lowndes County on North Oak Street, extension. We also have a satellite office in Tift County. Our staff consists of psychiatrists, advanced practice registered nurse (APRN), licensed clinical social workers, and licensed professional clinical counselors. We treat all age groups and provide:

- Psychiatric evaluation and management.
- Individual, family, and couple therapy for children, adolescents, and adults.
- Substance abuse /addiction assessment and treatment.
- In addition, we are the first provider in South Georgia to offer **Transcranial Magnetic Stimulation Therapy and Spravato Nasal treatment for depression**

We recognize that psychiatric disorders are painful conditions that involve many aspects of a person's life. Understanding these various aspects and addressing unique individual needs is crucial for recovery. At ARPCC, we use a comprehensive approach for evaluation, and every patient has an individual treatment plan to address these various aspects of care. We are glad you took the first step in seeking care for painful emotional issues. Now, you can expect the best professional efforts, respect, and quality of care from our team of service providers. An essential aspect of treatment is that you fully understand the risks and benefits of your care. We encourage you and your family to take an active part in your treatment process and let us know if you don't understand any part. Please review the following information and initial after each section. One of the ARPCC staff or your provider will review it with you once completed.

PSYCHOTHERAPY

Psychotherapy, or talk therapy, involves talking about your thoughts, feelings, and things troubling you in the therapy sessions, typically lasting 45 to 60 minutes. It sometimes may involve discussing intense emotional issues, and you may find it difficult initially. However, you will develop more confidence and become more comfortable as time passes. Your therapist is there to help you become more comfortable during this process. There are several different types of psychotherapy, each employing a different therapeutic approach. Sometimes, your therapist may combine different therapeutic techniques based on your needs or preferences. The therapist may typically see you weekly or every two weeks.

In the first session, your therapist will gather information about you and your needs. Sometimes this may require several sessions. This initial assessment will determine the psychotherapy goals of the treatment, the frequency of sessions, and the total number of sessions needed. Your therapist may ask him to do homework assignments or practice to build on what you have learned during therapy sessions. Over time, addressing your issues in sessions should improve your mood and change your thinking and feelings about yourself. It, in turn, should help you cope with your problems better.

Important Notice:

All the therapists working at ARPCC are independent contractors and not ARPCC employees. Independent contractors are responsible for their actions, and the ARPCC shall not be liable for the acts or omissions of any such independent contractors.

Patient Name: _____Date: _____

PLEASE REVIEW AND INITIAL THE FOLLOWING POLICIES FOR TREATMENT:

___ ITEM 1 - THERAPY SESSIONS

Initial Therapy sessions are scheduled for 45 or 60 minutes. In order that you receive your entire session, please be prompt for your appointment.

___ ITEM 2 - CONFIDENTIALITY

Initial All information is guarded by strict confidentiality. We require your written consent in order to release/obtain information.

___ ITEM 3 - CONSENT FOR TREATMENT MUST BE SIGNED PRIOR TO THE START OF YOUR APPOINTMENT

Initial

I hereby give consent for myself or the above-named patient to be treat/tested by my therapist. If the above-named patient is a minor who is/has been involved in any court proceedings, I have provided proof by the attached court documents, that I have the legal right to request treatment for the above-named minor. If you are **18 years of age**, you must sign yourself and are allowed to choose whether you wish anyone/parents to be present during your evaluation and treatment. Both parties must sign consent for treatment if seen for marital or co-joint therapy.

___ ITEM 4 - TERMINATION OF TREATMENT

Initial Assault or verbally threatening behavior towards staff, other patients, or physical property of AR Psychiatric & Counseling Center will be cause to terminate treatment and be held responsible for damages. Firearms and other weapons are prohibited, with exception for an officer of the law.

___ ITEM 5 - CANCELLATIONS

Initial **Cancellations must be made 24 HOURS before your session.** Your session time is reserved for you and you will be charged a **$50.00 no-show fee** for late cancellations or missed appointments. **A few of the therapist charge $100.00. Our office policy allows three no-show fees before terminating services.**

___ ITEM 6 - MANAGED CARE PLANS

Initial This practice has contracted with several managed care plans and will be handled according to our agreement with them. All co-payments must be paid at time of service. It is your responsibility to be aware of coverage variables, such as preventive health care, deductibles, etc., and to pay for services not covered by your insurance company. Following notification for the insurance company, any denied amounts would be due immediately, upon being notified by our office.

___ ITEM 7 - LETTERS AND/OR FORMS

Initial There will be a charge for any forms and/or letters that must be completed in this office by any practitioner or office staff.

___ ITEM 8 - FINANCIAL POLICY

Initial I acknowledge that I have read and understand the financial policies of this office.

___ ITEM 9 - TELEHEALTH POLICY

Initial I acknowledge that I have read and understand the telehealth policies of this office.

___ ITEM 10 – SOCIAL MEDIA POLICY

Initial I acknowledge that I have read and understand the social media policies of this office.

Patient Name: _____Date: _____

___ ITEM 11 - EMERGENCY SERVICES

Initial I agree to contact my psychiatrist or 911 in the event that I feel suicidal or violent in order to follow steps to protect the safety of others and myself.

___ ITEM 12 - NOTICE OF PRIVACY PRACTICES

Initial I acknowledge that I have received a copy of the Notice of Privacy Practices of this office.

_____ _____ _____

Patient Signature Initials Date

_____ _____ _____

Parent/Guardian Signature Initials Date

Items 1-12, initialed by me, indicate my understanding of legal Terms and Conditions in connection with the treatment of patients.

AR PSYCHIATRIC AND COUNSELING CENTER
FINANCIAL POLICY

We are committed to providing our patients with the best possible care and are pleased to discuss our professional services with you anytime. Your clear understanding of our Office Procedures and Financial Policies is very important. All patients must complete our "Patient Information Form" before seeing the Professional.

Payment of services is handled prior to your session. Your insurance company mandates you must pay your co-payment at the time of service. If you cannot pay, you may be asked to reschedule.

We accept cash, checks, Visa, and Debit. If a check is returned for insufficient funds, we will not accept another check from the patient. Payment will have to be cash, credit, or debit. There is a **$30 returned check fee**. We do not accept temporary or post-dated checks if you are a new patient.

We charge for missed/canceled appointments unless canceled at least 24 hours in advance. Our policy is to charge $50.00 for missed/canceled appointments. A few of the therapist charge $100.00. Please do not rely on appointment reminder calls, as this is a courtesy. Having three or more no-shows or cancellations of appointments can result in termination of treatment. Please help us serve you better by keeping scheduled appointments.
NOTE: You may be asked to reschedule if you are more than 15 minutes late for your appointment. If you feel you were charged in error, please discuss this matter with our office manager.

Due to the time involved for our medical providers and clerical staff, it is necessary to charge for ALL forms and letters. This is to be paid in advance and not billed to your insurance. **The cost for drafting letters and completing forms is $50.00 each.** If you choose, this office will provide you with a completed receipt showing charges and payments, which you may file with your insurance company.

In the event of a Divorce, we must have a copy of the Divorce Decree signed by a judge. The decree must state which parent has **Managing Conservatory Privileges for the minor child.**

REGARDING INSURANCE ASSIGNMENT

We will only file claims with insurance companies we are contracted with. In order to achieve this, we must have all current insurance information on file.

If there are any changes in your insurance coverage, you must notify our office 5 days prior to your next appointment or the visit will be self-pay or rescheduled.

The patient must stay current with the payment of their deductibles and co-payments. All information this office gives in reference to your insurance coverage is based on information obtained from your insurance company, is only descriptive of your benefits, and is not a guarantee of payment by your insurance company. An insurance company may quote benefits and give authorization, but clearly state in their disclaimer this is not a guarantee of payment. Therefore, any amount we collect at the time of service or quote as your responsibility is an estimate only. You are ultimately responsible for any and all balances on your account.

Should you have any problems regarding your account or about the filing of claims, fees, or billing records, please do not hesitate to ask our office Staff.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICIES OF AR PSYCHIATRIC & COUNSELING CENTER.

_____ _____

Signature **Date**

AR PSYCHIATRIC AND COUNSELING CENTER
SOCIAL MEDIA POLICY

'Social media' refers to online and mobile tools that people use to share opinions, information, experiences, images, and video or audio clips, and includes websites and applications (apps) used for social networking. Common sources of social media include, but are not limited to, social networking sites such as Facebook and LinkedIn, blogs (personal, professional and those published anonymously) and microblogs such as Twitter, content-sharing websites such as YouTube and Instagram, and discussion forums and message boards.

This document outlines our office policy related to the use of Social Media. Please read it carefully to understand how our licensed mental health professionals conduct themselves on the Internet and how you can expect a response to interactions that may occur between you and your doctor, nurse, or therapist using social media or technology. If you have any questions about this policy, please bring them up during your visit. As new technology develops, this policy may be updated to reflect those changes, and you will be notified in writing. You may obtain a copy of this policy upon request. Our primary concern is your privacy and maintaining a professional therapeutic relationship with our patients.

EMAILS, CELL PHONES, FAXES, MOBILE DEVICES

Secure and private communication cannot be guaranteed entirely using non-secure technology such as cell/smart phones, mobile devices, tablets, regular email, or via our website. It is your right to decide whether using this type of non-secure technology may be permitted and under what circumstances. Should you choose to contact your provider using any type of non-secure technology, it will be considered implied consent (with your permission) that we respond and return messages in the same non-secure manner, and you agree to take the risk that such communication may be intercepted. Please be advised that although it is a convenient way to communicate, it is very important that you are aware that computers, email, and cell phones, including text messaging without encryption, can be accessed by unauthorized people. Some risks include: conversations being overheard; emails can be sent to the wrong recipient; others may view pop-up messages on your cell phone, and notification services may alert others of your location. Service providers retain a log of all emails, and though it is unlikely someone will look at these logs, they can be read by system administrators of the internet service provider. AR Psychiatric & Counseling center does not use encryption in our email system; therefore, should you choose to contact us via email, we ask that you limit your communication to administrative issues only, such as changing appointments or billing questions, to protect your privacy. Our fax is secure, and if you need to communicate clinical information, we ask you to do so by faxing us at 229-244-2038. If you communicate confidential or private information via text or email, we assume you have made an informed decision and will view this as an agreement to take the risk and will honor your desire to communicate on such matters. We will not initiate contact via text or email without your consent or as stated above.

NEVER USE EMAIL, TEXT OR FAX FOR EMERGENCIES. Emails or faxes may not be checked daily. Due to computer network problems, emails may not be delivered or there may be a disruption in connection. In the event of emergency, please call 911.

SOCIAL MEDIA NETWORKING SITES

Networking sites such as Facebook, Twitter, or LinkedIn are NOT secure. Using Wall posts, replies, or other means of engaging in conversations on these sites could compromise your confidentiality. In addition, exchanges on social networking sites can become part of your legal medical record. This policy serves to notify you that being linked as friends or contacts on these sites can compromise your confidentiality, privacy, and therapeutic relationship. As in any other public context, you have control over your own description regarding the nature of your acquaintances. If you choose to disclose information regarding your relationship with one of our clinical professionals, you acknowledge that you understand and accept the risk associated with using social networking. We do not accept friend requests from former or current patients to protect your privacy and maintain a professional boundary in the therapeutic relationship.

LOCATION BASED SERVICES

If you use location-based services on your cell mobile device, you may compromise your privacy while attending sessions in the office. We do not list the practice as a check-in location on various sites such as Foursquare; however, it may be found as a Google location, and if you have passive Location Based Services enabled, it may show that you are at the location regularly and others may surprise you are in treatment at AR Psychiatric & Counseling Center. Please ask your service provider if you are unware of how to disable this setting.

WEBSITE

Our website www.arpccenter.com is for general information purposes only and should not be used as a substitute for your mental health care. Although we have a contact us link, please note that the webpage is not a secure means of communicating clinical information and should be limited to non-clinical questions.

SEARCH ENGINES

It is not a regular part of our practice to search for patients on Google, Facebook other search engines. Extremely rare exceptions may be made during times of crisis (in the event the doctor or therapist feels you are a danger to yourself or others), and all other means to contact you have been exhausted, a search engine may be used to ensure your welfare. If this occurs, this will be fully documented in the clinical record and discussed with you at your next visit.

FOLLOWING

Our licensed professionals will not follow any client on Twitter, Instagram, blogs, or other apps/websites. If there is content you wish to share from your online life, please bring it into the session, where it can be explored together. If you follow any of our licensed therapist's blogs, be aware that your privacy may be compromised if you use an easily recognizable name.

BUSINESS REVIEW SITES

You may find our psychiatry and psychotherapy services on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some sites include forums where users rate their providers and add reviews or comments. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find our listing on any of these sites, please be aware that a listing for AR Psychiatric & Counseling Center is NOT a request for a testimonial, rating, or endorsement from you as a patient. You have the right to express yourself on any site, but due to confidentiality, we cannot respond to any review on any of these sites, whether positive or negative. You are urged to take your privacy as seriously as we take our commitment to your confidentiality. You should also be aware that if you use these sites to communicate with one of our professionals, it is possible it will never be seen. If you choose to write something on a business review site, remember that you may be sharing personally revealing information in a public forum.

ACKNOWLEDGEMENT OF REVIEW OF SOCIAL MEDIAL POLICY

By signing below, you are indicating that you have read this document (all pages), understand your rights as a client/patient, and accept the responsibility as stated. You may request a printed copy of the Social Media Policy, and all questions regarding these policies have been answered to your satisfaction.

Printed Name of Patient:_____ Date:_____

Signature of Patient/Legal Representative:_____

AR PSYCHIATRIC AND COUNSELING CENTER

Informed Consent for Telemental Health Services

Information About Telemental Health:

Telemental Health involves using two-way videoconferencing to enable you to participate in treatment sessions with your provider (psychiatrist/ therapist) remotely, such as at your home or another private location. Treatment sessions are similar to in-person sessions, in that you and your provider can communicate in real-time while seeing each other over live video.

While telemental health is similar to in-person care, there are differences and some associated limitations. Here are the expected benefits, as well as risks, to consider before proceeding with it.

Expected Benefits:

- Improved access to medical care by enabling you to remain at a remote site, such as your home, while still receiving regular medical care.
- Greater consistency in scheduling.

Possible Risks:

- Reduced ability to perform certain aspects of a physical examination or evaluation.
- Insufficient information (e.g., poor resolution of images or audio) to allow for appropriate medical decision-making by your provider.
- Technical problems or failures interrupting or delaying treatment sessions.
- Failure of security protections resulting in a breach of protected health information

Here is more information regarding how telepsychiatry is conducted in our office:

- **IMPORTANT:** ***You must be in Georgia for Telehealth sessions.***
- Telemental health appointments will be conducted through the HIPAA-compliant, encrypted platform Doxy.me/ Doximity, or via phone if the encrypted platform fails.
- You will need to use a camera-enabled computer, tablet, or smartphone during the session. Please advise your provider of an alternate telephone number or another contact method in the event technical problems interrupt your treatment session.
- It is important for your provider to know where you are physically located during your treatment session in case an emergency arises. Please try to establish a consistent location for you to participate in telemental health sessions.
- In an emergency, your provider may advise you to proceed to an emergency room or other direct care facility for further evaluation and treatment. Please designate at least one emergency contact person and the closest emergency room to your location.
- It is your responsibility to contact the practitioners in your area if an emergency arises and include but are not limited to the following:
  a. 988 Suicide & Crisis Lifeline
  b. GCAL (Georgia Crisis & Access Line) – 800-715-4225
  c. National Suicide Hotline – 800-273-TALK (8255)
  d. Other Local Emergency Number: _____

- At the discretion of your provider, and for controlled substance prescriptions, you may be required to participate in periodic in-person visits to augment telehealth sessions.
- We cannot conduct a session while you are operating a moving vehicle or not in a fixed location to protect your safety and the safety of others.
- For minor patients, we require written consent from a parent or legal guardian for telemental health sessions (see the signature section below).

- It is important for you to be on time for telemental health appointments. If you need to cancel or change your appointment, you must notify your provider in advance by telephone.

Privacy and Confidentiality:

- It is important for you to be in a quiet, private space free of distractions (including cell phones or other devices) during sessions.
- It is important to use a secure internet connection during treatment sessions rather than public or free Wi-Fi.
- Confidentiality still applies for telemental health sessions; treatment sessions will not be recorded without the express permission of all participants, including you and your psychiatrist/therapist.

In-Person Care:

- You have the right to discontinue telemental health sessions and proceed through in-person care if you feel it would be more beneficial to you.
- Your provider may determine that telemental health is no longer appropriate due to certain circumstances and resume in-person treatment sessions.

Patient Consent for the Use of Telehealth:

By signing this form, I indicate the following:

- I have read and understand all the expected benefits and risks associated with telemental health, and any questions have been answered to my satisfaction.
- I understand that I have the right to withhold or withdraw my consent to the use of telemental health in the course of my care at any time and proceed with in person care without affecting my right to future care or treatment.
- I understand that the laws that protect the privacy and the confidentiality of medical information also apply to telehealth; that appropriate measures will be taken to secure transmitted information and maximize privacy and confidentiality.
- I hereby give my informed consent for the use of telemental health in my medical care.

Patient Name: _____ Date: _____DOB: _____

Patient Signature: _____

Parent/Guardian or Other Responsible Party: _____

Name: _____ Signature: _____Date: _____

Witness Name: _____

Signature: _____ Date: _____

AR PSYCHIATRY AND COUNSELING CENTER
NOTICE OF PRIVACY PRACTICES

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

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

AR Psychiatric & Counseling, LLC and its contracted providers may use or disclose your protected health information (henceforth termed PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

A."PHI" refers to information in your health record that could identify you.
B."Treatment, Payment and Health Care Operations" refers to

- Treatment is when AR Psychiatric & Counseling, LLC provides, coordinate or manage your health care and other services related to your healthcare. An example would be when we consult with another health care provider, such as your family physician or your psychologist.
- Payment is when we obtain reimbursement for your health care. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- Heath Care Operations are activities that relate to the performance and operation of my 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.

C."Use" applies only to activities within my (office, clinic, practice group, etc), such as sharing employing, applying, utilizing, examining, and analyzing information that identifies you.
D."Disclosure" applies to activities outside my (office, clinic, practice group, etc.) such as releasing, transferring, or providing access to information about you or other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of your treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your "*Psychiatric Notes*". "Psychiatric Notes" are notes we have made about our conversation during our sessions which we have kept separate from the rest of your medical records. These notes are given a greater degree of protection that PHI.
You may revoke all such authorizations (of PHI or Psychiatric 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. Possible Use or Disclosure of PHI or Psychotherapy Notes without Consent or Authorization

AR Psychiatric & Counseling, LLC and its contracted providers may use or disclose PHI without your consent or authorization in the following circumstances:

- ***Child Abuse*** **:** If we have reasonable cause to believe that a child has been abused, we must report that belief to the appropriate authority
- ***Adult and domestic abuse*****:** If we have reasonable cause to believe that a disabled adult or elder person has had physical injury or injuries inflicted on them, other than by accidental means, or has been neglected or exploited we must report that belief to the appropriate authority.
- ***Health Oversight Activities*****:** If we are subject of an inquiry by the Composite State Board of Medical Examiners or the Composite State Board of Professional Counselors, Social Workers and Marriage and Family Therapists, the Department of Community Health or any other Government regulatory agency with appropriate authority, we may be required to disclose your PHI or psychotherapy records.
- ***Judicial and Administrative Proceedings*****:** If you are involved in court proceedings and a request is made about the professional services provided to you, we may provide relevant information regarding the dates and times of service. We may also provide other relevant PHI , however, psychotherapy notes, or any information that is privileged under state law, will not be released without your consent or court order. Please be advised that the privilege does not apply when you undergo an evaluation for a third party or when the valuation is court ordered; in these instances , you will be informed as to whether your records are privileged
- ***Serious Threat to Health and Safety*****:** If we determine, or pursuant to the standards of Psychiatry should determine, that you present a serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.
- ***Worker's Compensation*****:** We may disclose PHI regarding you or authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work related injuries or illness without regard to fault.

Patient's Rights and Psychiatrist's Duties

Patient's Rights

- ***Right to Request Restrictions***: you have the right to request restrictions on certain uses and disclosures of PHI. However, we are not required to agree to a restriction 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 going to Center for Family Psychiatry Inc. and its contracted providers on your request we will send the bill to another location.)
- ***Right to Inspect and Copy*****: You have the right to inspect or obtain a copy (or both)** of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record subject to reasonable fees for copying. We may deny access to your PHI under certain circumstances, but in some cases you may have the decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- ***Right to Amend***: You have the right to request an amendment of PHI as long as 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. On your request we will discuss with you the details of the accounting process.
- ***Right to Paper Copy***: You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Psychiatrist's or Providers Duties

- We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- We reserve the right to change privacy policies and practices with respect to PHI.
- If we revise the policies and procedures we will provide you with a revised notice via our message board at the front desk.

IV. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records or have other concerns about your privacy rights, you may contact *Renu Gupta who is the Privacy Officer for the practice*.

If you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to Attn: Renu Gupta, AR Psychiatric & Counseling, LLC, 3312-D North Oak Street Ext., Valdosta, GA 31605.

You may also send a written complaint to the Secretary of the U.S. Dept of Health and Human Services.
The Privacy Officer listed above can provide you with the appropriate address upon request.
You have specific rights under Privacy Rule. AR Psychiatric &Counseling and its contracted providers will not retaliate against you for exercising your rights to file a complaint.

V. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on 11/01/2011. AR Psychiatric & Counseling, LLC and its contracted providers reserve the right to change the terms of this notice and to make the new notice effective for all PHI that we maintain. Any revised notices will be posted at the front desk.

Please Sign _____Date_____

(Patient or legal Guardian if under 18)

Print "signature" name if different from above_____

AR PSYCHIATRIC AND COUNSELING CENTER

Consent for Communication

Patient Name:_____ Date:_____

Most patients have family members and friends that occasionally become involved in their care. For example, your spouse calls to confirm your appointment time; or your adult child calls with questions about your medication; or a friend, who helps you, calls because they are concerned about you. You have a right to request that we restrict how protected health information about you is used or disclosed.

If you have anyone that you would allow us to communicate with, please list them below. Due to privacy regulations, we cannot speak to anyone but the patient unless we have your written permission.

I give the ARPCC Clinic staff my permission to speak with the following individuals regarding my care.
Note: If you prefer that we not speak with ANYONE, please write "No One" across the lines

Name of Family or Friend	**Relationship**

Restrictions to Communications: _____

_____

I request that all communications (by telephone, mail or otherwise) by ARPCC Clinic staff be handled in the following manner:

* For written communications Address to: _____

_____

_____

* For oral communications Call: _____
(Telephone number)

May we leave a message? ☐ Yes ☐ No

I understand that I have the right to revoke this authorization in writing at any time. I request that my confidential information be handled in the following manner and authorize AR Psychiatric & Counseling Center staff to disclose information only to those individuals listed above **and** in the manner stated for oral and written communications. Any other release of information will require a signed authorization for Release of Medical Information.

_____ _____
Signature of Patient/Legal Guardian (minors 12-17 must sign) Date

_____ _____
ARPCC Staff Date