

818 COMMERCIAL STREET
SUITE 406
ASTORIA, OREGON 97103



PHONE: 503.550.7873
FAX: 503.406.2297
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AGREEMENT AND INFORMED CONSENT FOR TREATMENT

Treatment Agreement

Welcome! I appreciate the opportunity to serve you as a psychologist. This document (the AGREEMENT) contains important information about my professional services and business policies, as well as summary information about the Health Insurance Portability and Accountability Act (HIPAA).

HIPAA is the federal law that provides for privacy protections and patient rights regarding your Protected Health Information (PHI). HIPAA regulations require that I provide you with a NOTICE OF PRIVACY PRACTICES (the NOTICE) regarding the use and disclosure of your PHI. The law also requires that I obtain your signature acknowledging that I have provided you with this information at the start of treatment. Although these documents are long and sometimes complex, it is very important that you read them carefully before signing. You will also receive copies of this information for your records. If you have any questions or concerns about this information, please let me know so that we can address them.

When you sign the AGREEMENT, it represents a formal agreement between us. You may revoke this agreement in writing at any time, and that revocation will be binding unless (1) I have already taken action in reliance upon it, (2) there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy, or (3) you have not satisfied financial obligations incurred by you.

Psychological Evaluation Services

Psychological assessment and evaluation may provide valuable insight into thought processes and emotions, and the related impact on overall functioning in life. A comprehensive psychological evaluation can assess cognitive, learning, and/or psychological functioning in order to identify related strengths and weaknesses and provide recommendations about how to enhance your success in many aspects of life. In my scope of practice, psychological evaluations are conducted to:

- Clarify psychological diagnoses and level of functioning
- Identify cognitive and emotional strengths and challenges
- Assess factors affecting ability to learn and barriers to learning
- Assess factors affecting gainful employment and barriers to employment
- Evaluate need for support, auxiliary aids, and accommodations in postsecondary education and/or in the workplace
- Update documentation for academic accommodations in higher education
- Provide supporting documentation for SSI/SSDI claims
- Clarify treatment, education, or case management plans and recommendations

If you have been referred for the evaluation by another person or agency, I will ask for your

permission to send the report to that person/agency, so that they may use these results in assisting you to the best of their ability. *You have the right to refuse to let me send the evaluation to them; however, in some circumstances, I may not be able to provide the evaluation services if I cannot share the results.* Please discuss this matter with me before the evaluation begins if you have any questions or concerns.

If you are interested in receiving an evaluation, you will go through four primary steps:

1. Initial contact to discuss services and fees, and to schedule the appointment(s)
2. Interview with you and possibly with other individuals who have helpful information for your evaluation (e.g. relatives, caregivers, teachers, medical doctors, mental health professionals)
3. Session(s) to administer evaluation measures
4. Feedback session upon completion of the report in which the findings are discussed with you and you receive a copy of the report (Please note: In certain cases, if Dr. Bee has been hired by someone other than you--such as by an attorney or a caseworker--you may not receive direct feedback or a copy of the report. If this is the case, Dr. Bee will discuss it with you during your initial contact)

Evaluations vary in length and number of sessions required depending on the nature of the evaluation. The length of time the evaluation will take depends on the reasons you are receiving an evaluation and the number of tests we will be doing. The evaluation typically lasts between four and six hours, but may be longer or shorter.

The Benefits and Risks of Psychological Evaluation

Psychological evaluations can be a helpful tool for understanding your strengths and challenges and for identifying ways to improve your life. However, there are also risks associated with evaluations. You may feel tired after completing the evaluation session and you will likely find some of the questions or tasks to be challenging. You may also have thoughts or feelings come up before, during, or after the evaluation that may be uncomfortable or unpleasant. You may be dissatisfied with or dislike the results of the evaluation or the recommendations, and they may not provide you with the outcome you were hoping for. Additionally, the evaluation may include information that you would not want the person/agency that referred you to know. Because of these risks, it is important for you to think about and discuss with me, before we begin the evaluation, any concerns you have about the evaluation or about releasing the evaluation to the person who referred you.

In addition to risks in doing the evaluation, there may also be risks in not doing the evaluation. You may continue to experience your struggles without additional information that may be helpful for making changes in your life. Other people working with you may not be able to provide as much help or support to you because they may not know some important challenges that affect you. Additionally, you may not be able to receive the services or support that would be beneficial if you do not complete the evaluation.

Considering the risks involved in psychological evaluation is important; however, the possible benefits of the evaluation are worth the risks most of the time. Generally, people seek evaluations to help figure out some difficulty they have been experiencing and to identify ways to improve on those difficulties. The evaluation process may help you understand the way you think and feel, and may identify strengths you have that may be used to help improve those challenges. Whether or not to complete the evaluation is up to you, and I encourage you to talk with me about any of your concerns about the process. I do not accept evaluation cases unless I believe I may be helpful. As such, I will enter the evaluation

process with optimism about the ways in which the evaluation may be beneficial for you.

Legal Proceedings

If you are involved in or anticipate becoming involved in any legal proceeding (e.g., custody, divorce, or civil proceedings), please notify me as soon as possible. It is important for me to understand how, if at all, your involvement in these proceedings might affect our work.

Office Policies

(A) Phone Contact and Emergencies: For your information, I use a cellular phone as my primary business line and therefore cannot guarantee absolute privacy. (The same limitation applies to e-mail correspondence.) I check my voice mail several times per day during business hours. Phone calls are returned as soon as possible, usually within 24 hours, except on weekends and holidays. I do not answer the phone when I am with patients, and my availability at other times cannot be guaranteed. You may leave a confidential voice mail for me at any time, but messages left after 5:00 pm may not be received until the following morning. Because voice mail technology is not error proof, if you have not heard back from me by the end of the next day, please feel free to call again since it is likely that I did not receive your original message. Please be sure to state if you are calling about an urgent matter. In the case of an emergency, if you cannot reach me, you should call the **Clatsop County Behavioral Healthcare Crisis Line (503-325-5724)**, dial **911**, or go to the nearest hospital emergency room. The person best able to help you in emergency situations is your primary clinician or therapist. As your evaluator, I am not your therapist and may not be available to you in emergency situations.

(B) Billing & Fees: Payment for services is an important part of any professional relationship. You are ultimately responsible for seeing that my services are paid for.

Psychological evaluation services are billed at \$150 per hour. Psychological testing fees include the time spent with you, the time spent interviewing others, the time spent reviewing your records, the time needed for scoring and interpreting the test results, and the time needed to write a report on the findings. The amount of time involved depends on the tests used and the questions the testing is intended to answer.

One-half of the agreed upon payment is due at the beginning of testing with the remaining balance due when the report is delivered to you or released to a third party. Patients experiencing financial hardship are invited to raise their financial concerns so that we can discuss payment options. There is a \$20 charge for dishonored checks. Additional payment information can be found in the PAYMENT CONTRACT FOR SERVICES.

NOTE: If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge \$200 per hour for preparation and attendance at any legal proceeding.

(C) Appointments and Cancellations: Appointments are made directly with me. With sufficient notice, appointments can often be rescheduled. Be aware that it may be a number of weeks before your appointment can be rescheduled. Due to the amount of time reserved for your evaluation appointment, if an evaluation appointment is canceled with less than 48 hours notice, I reserve the right to incur a late cancellation fee of \$50 per hour scheduled. Appointments that are missed without any notice may incur a no-show fee of \$100 per hour scheduled. It is important to note that insurance companies do not reimburse for canceled or missed appointments, so you will be personally responsible for this fee. If you are late for your evaluation and have not called

me, I will keep your time free until one hour after the scheduled start time. If you fail to cancel or to attend your appointment on two occasions, you may not be given further opportunity to participate in the evaluation.

(D) Drugs and Alcohol: A patient who attends an evaluation under the influence of drugs or alcohol may not be seen. Such an incident will be treated as a missed appointment, and the patient may be billed.

Health Insurance

You may have health insurance benefits that provide full or partial coverage for psychological evaluations. If you are using health insurance to pay for evaluation services, you need to be aware of what this means. Your health insurance plan requires cooperation between the patient, provider, and insurance company to provide services as efficiently as possible. In many cases, I will be required to provide information about your treatment as well as a diagnosis. I may also be required to provide additional clinical information, such as treatment plans or summaries, or even copies of your entire Clinical Record. Released information will become part of the insurance company records, and while all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands.

Health insurance companies may not cover all services or conditions, and they may only cover a limited number of sessions. Some insurance plans require pre-authorization or they will not cover your evaluation services. You are responsible for obtaining the initial pre-authorization, if necessary. It would also be very helpful if you would check the specifics of your insurance benefits, if any, prior to our first meeting. You remain responsible for your entire bill regardless of whether insurance covers treatment costs or whether you are the primary insured person.

Confidentiality and the Limits on Confidentiality

Confidentiality is the obligation not to disclose any patient information obtained during a professional relationship without permission. Confidentiality is a cornerstone of effective psychological services, and the law protects confidential communications between a patient and a psychologist. Information is never released to anyone, including your spouse/partner or family, without your written consent, **except** as required by law or ethical guidelines.

I will make every effort to protect your confidentiality when I call you by phone. If you have special instructions for how I should leave messages, please let me know. Otherwise, I will generally state my name and leave a brief message. If we happen to meet outside of our professional contact, I will not reveal our professional relationship and, unless otherwise arranged, I will not even acknowledge that I know you.

HIPAA allows me to use or disclose confidential information including, but not limited to, your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations, as long as I have your informed written consent, signified by signing this document. For purposes outside of treatment, payment, and health care operations, I can only release your information if you sign an AUTHORIZATION. However, you should be aware that there are some additional legal and ethical exceptions or limits to confidentiality and some situations in which I am permitted or required to disclose information without your consent or AUTHORIZATION. For more information, please consult the NOTICE OF PRIVACY PRACTICES. I will try to disclose only information that is necessary to meet the needs of the situation.

Clinical Record

As a psychologist, I maintain confidentiality in creating, storing, accessing, transferring, and

disposing of records in any medium. Your Clinical Record includes your reasons for seeking services, how your life is being impacted, your diagnosis, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, testing protocols, and any reports that have been sent to anyone, including psychological evaluation reports. By submitting a written request, you may examine and/or receive a copy of your Clinical Record, except in circumstances where disclosure would be injurious to you or would constitute an immediate and grave detriment to your treatment. In such circumstances, I may provide you with an accurate and representative summary of your Clinical Record, if requested. Professional records can be very confusing and/or upsetting to an untrained reader. For this reason, I recommend that you review them in my presence or with another mental health professional. In most circumstances, I will charge a copying/printing fee of \$30 for the first ten pages, 50¢ per page up to 50 pages, and 25¢ per page for over 50 pages, plus any postage. If you wish to review your Clinical Record, please address your request to me, so that we can discuss the best way to make this happen.

All records and notes are kept double-locked or password protected, and all records are retained for a minimum of seven years as required by law. In the event of your death, the privilege to access your record passes to your estate. In the event of my own incapacitation, withdrawal, or death, another licensed psychologist will assume responsibility for my records. Currently, my records custodian is Brad Larsen-Sanchez, Psy.D..

Agreement and Consent to Treatment

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ, UNDERSTOOD, AND AGREED TO THE TERMS OF THIS DOCUMENT. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGMENT THAT YOU HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES DESCRIBED ABOVE.

Patient Name (or person acting for patient)

Date

Signature

Relationship to patient

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CLIENT INFORMATION

Please provide the following information as honestly and completely as possible. If you do not feel comfortable answering a question, leave it blank and we will discuss it during our appointment. If you need more space, feel free to use the margins or attach an additional page. All answers are strictly confidential in accordance with the CONSENT TO EVALUATION.

Referred By: _____

Full Name of Patient:		Social Security # (optional)
Home Address:		Date of Birth:
		Age:
Home Phone:	May I leave messages at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender:
Cell Phone:	May I leave messages at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital/Relationship Status:
E-mail Address:		Ethnicity:
Work/School Address:		Nation of Origin:
		Military Veteran Status:
Work Position/Title:		Highest Educational Degree:
Work Phone:	May I leave messages at this number? —	
Emergency Contact:		Relationship:
Emergency Contact Address:		Emergency Contact Phone #1:
		Emergency Contact Phone #2:
Parent/Guardian (if under 18):		Relationship (if guardian):
Parent/Guardian Address (if different):		Parent/Guardian Phone #1:
		Parent/Guardian Phone #2:

Family & Relationship History

1. **Family of Origin:** Please list the members of your family of origin (parents, brothers, sisters, etc.):

<u>Name</u>	<u>Relationship</u>	<u>Age</u>	<u>Occupation/School</u>	<u>Lives with you?</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. Is there any family history of mental health or substance abuse issues?

3. Are there any special circumstances related to your childhood? (adoption, separation, divorce, etc.)

4. Were you raised with any particular religious or cultural beliefs?

5. What are your current relationships like with your family of origin?

6. **Current Family:** Please list the members of your current/immediate family (if different from above):

<u>Name</u>	<u>Relationship</u>	<u>Age</u>	<u>Occupation/School</u>	<u>Lives with you?</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

7. How would you describe your social and relationship history? (active, isolated, etc.)

8. Who do you consider to be your primary social supports right now?

9. Are you currently in a romantic relationship? If so, for how long?

10. Have you ever been abused or witnessed abuse? (physical, sexual, emotional, etc.)

Physical & Mental Health History

11. Past Hospitalizations or Major Medical Problems:

12. Current Medical Conditions or Allergies:

13. Current Prescription Medications:

14. Date of Last Complete Physical:

15. Primary Care Manager:

16. Primary Care Manager's Phone:

17. Current Non-Prescription Medications (vitamins, supplements, diet pills, etc.):

18. Have you ever had a head injury?

19. Do you experience any serious concentration or memory problems?

20. Have you ever received mental health or substance abuse services? If so, when, where, and with whom?

21. Do you have any history of suicidal thoughts or attempts? If so, when?

22. Do you have any other history of self-harm? (cutting, burning, etc.)

23. Do you have any history of harming others?

24. Do you have any history of substance use problems? (excessive use, dependency, etc.)

25. Is there anything else I should know about your physical or mental health?

Other Relevant History

26. Describe any relevant work or school issues:

27. Describe any relevant legal history:

28. Is there anything else I should know about your history?

Symptom Checklist

29. Please check any of the symptoms that you are having or have had recently:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Impulsiveness |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Irritability | <input type="checkbox"/> Weight Change | <input type="checkbox"/> Feeling Worthless |
| <input type="checkbox"/> Sadness/Depression | <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Violent Behavior | <input type="checkbox"/> Excessive Sweating |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Loneliness/Isolation | <input type="checkbox"/> Body Image Concerns |
| <input type="checkbox"/> Worrying | <input type="checkbox"/> Sleep Difficulties | <input type="checkbox"/> Speech Difficulties | <input type="checkbox"/> Heart Palpitations |
| <input type="checkbox"/> Memory Difficulties | <input type="checkbox"/> Perfectionism | <input type="checkbox"/> Physical Pain | <input type="checkbox"/> Sick Often |
| <input type="checkbox"/> Low Energy | <input type="checkbox"/> Sexual Difficulties | <input type="checkbox"/> Work Difficulties | <input type="checkbox"/> Avoiding People |
| <input type="checkbox"/> Eating Behavior Issues | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Poor Judgment | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Obsessive/Compulsive | <input type="checkbox"/> Easily Distracted |
| <input type="checkbox"/> Social/Family Conflicts | <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Disorganized Thoughts |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Muscle Tension | <input type="checkbox"/> Elevated Mood | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Low Self-Esteem | <input type="checkbox"/> Intrusive Thoughts | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Thoughts of Harming Others |

30. Please add any useful details about your checked items above:

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PAYMENT CONTRACT FOR SERVICES

This document is intended to clarify the payment policies for services contracted with Dr. Heather Bee. The Person Responsible for Payment is required to sign this document before any services are provided.

Your insurance policy, if any, is a contract between you and the insurance company. I am not part of the contract between you and your insurance company, and you are responsible for knowing what your insurance covers. As a service to you, I am willing to assist with insurance issues and questions. I am also often willing to submit claims to insurance companies and other third-party payers. However, I cannot guarantee such benefits or the amounts covered, and I am not responsible for the collection of such payments. In some cases, insurance companies or other third-party payers may not consider certain services to be reasonable or necessary, may determine different standard and customary rates, or may determine that services are not covered at all. In such cases, the Person Responsible for Payment is responsible for the costs of all services not covered by insurance companies or other third-party payers. The Person Responsible for Payment is also responsible for all costs not paid by insurance companies or third-party payers after 60 days.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere, this amount will be collected by me until the deductible payment is verified by the insurance company or third-party payers. All insurance benefits will be assigned to me by the insurance company or third-party payers unless the Person Responsible for Payment pays the entire balance each session.

Patients are responsible for payments at the time of service. Cancellations with less than 48 hours notice may incur a late cancellation fee of \$50 per hour scheduled and scheduled appointments that are missed without any notice may incur a no-show fee of \$100 per hour scheduled. Please note that insurance companies do not reimburse for canceled or missed appointments, so you will be held responsible for this fee.

Payment methods include cash or check, unless other arrangements have been made. For more information on Billing & Fees or on Health Insurance, please review the AGREEMENT AND INFORMED CONSENT FOR TREATMENT.

If you have any questions regarding this document, please be sure to ask me.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ, UNDERSTOOD, AND AGREED TO THE TERMS OF THIS DOCUMENT.

Patient Name

Person Responsible for Payment

Signature

Date

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HEATHER A. BEE, PSY.D.
LICENSED PSYCHOLOGIST

Insurance Information Form

Patient Information

Patient name: _____ Date of Birth: _____ Age: _____
Social Security Number: _____ Phone Number: _____
Home street address: _____ Apt: _____
City: _____ State: _____ Zip: _____

Primary Insured Identification

Check if self

Name: _____ Phone: _____
Address: _____
Relationship to you: _____ Date of Birth: _____

Insurance Company Information

Insurance Company: _____
Address: _____
Customer Service Phone: _____
Primary Insured ID#: _____ Group ID#: _____

Heather A. Bee, Psy.D., Licensed Psychologist has my permission to bill my insurance company. I authorize Heather A. Bee, Psy.D., Licensed Psychologist or her direct agent to release any information necessary to process my claims. I further authorize that my insurance benefits be paid directly to Heather A. Bee, Psy.D., Licensed Psychologist.

Signature: _____ Date: _____

Verification of Benefits

For office use only

Verification Date: _____ Name of Insurance Rep: _____
Effective Date of Policy: _____
Deductible: _____ Applies? Yes No Deductible Amt used: _____
Co-pay/Co-ins: _____ Sessions allowed: _____ Used: _____
Treatment plan required: Yes No After _____ sessions

Notes:

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HEATHER A. BEE, PSY.D.
LICENSED PSYCHOLOGIST

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FAX: 503.406.2297
EMAIL: INFO@DRHEATHERBEE.COM

NOTICE OF PRIVACY PRACTICES

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

Understanding the contents of your Clinical Record and how that information is used will (1) help you to better understand when others may have access to your health information and (2) assist you in making more informed decisions when authorizing disclosures. Your record is the physical property of Dr. Heather A. Bee; the information within the record belongs to you. In using and disclosing your health information, it is my policy to be in compliance with the Privacy Standards of the federal Health Insurance Portability and Accountability Act (HIPAA).

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

I may use or disclose your *Protected Health Information (PHI)* for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify this statement, the following definitions are provided:

- **“Use”** applies to activities within my office such as utilizing, examining, and analyzing your PHI.
- **“Disclosure”** applies to activities outside my office, such as releasing, transferring, or providing access to your PHI.
- **“Protected Health Information (PHI)”** refers to any individually identifiable health information maintained or transmitted by me that relates to (1) the past, present, or future physical or mental health or condition of an individual; (2) the provision of health care to an individual; or (3) the past, present, or future payment for the provision of health care to an individual.
- **“Treatment”** is when I provide, coordinate, or manage your health care and other services related to your health care. This includes when I consult with other health care providers, such as your family physician or another psychologist, and when I make referrals.
- **“Payment”** includes what a health care plan does to collect premiums, determine eligibility and coverage, and provide payments. This includes when I disclose your PHI to your health insurer to determine eligibility or coverage or to obtain reimbursement.
- **“Health Care Operations”** are activities that relate to the performance, operation, and maintenance 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.
- **“Consent”** refers to your consent and agreement, which you indicate by your signature, on the ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES or the AGREEMENT AND INFORMED CONSENT FOR TREATMENT.

Uses and Disclosures Requiring Authorization

I may use or disclose confidential information, including but not limited to PHI, for purposes of treatment, payment, and health care operations when your written informed consent has been obtained. I may also use or disclose your PHI for purposes outside of treatment, payment, and health care operations only with your written AUTHORIZATION. An “**Authorization**” is specific, written permission above and beyond general consent. When information is requested for purposes other than treatment, payment, and health care operations, I will obtain an AUTHORIZATION from you before releasing the information.

You may revoke an AUTHORIZATION at any time, provided the revocation is in writing. You may not revoke an AUTHORIZATION to the extent that (1) I have relied on the AUTHORIZATION or (2) 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

I may use or disclose your PHI without your consent or authorization in the following circumstances. If any of these situations arise, whenever possible, I will make every effort to discuss it with you before taking action, and I will limit my disclosures to what is minimally necessary.

- ◆ **Child Abuse:** If I have reasonable cause to believe that a child has been abused, I may be required to report the abuse and turn over PHI. Regardless of whether I am required to disclose PHI, I have an ethical obligation to prevent harm to my patients and others. I will use my professional judgment to determine whether it is appropriate to disclose PHI.
- ◆ **Abuse of Mentally Ill or Developmentally Disabled Adults:** If I have reasonable cause to believe that a mentally ill or developmentally disabled adult has been abused, I may be required to report the abuse and turn over PHI. Regardless of whether I am required to disclose PHI, I also have an ethical obligation to prevent harm to my patients and others. I will use my professional judgment to determine whether it is appropriate to disclose PHI.
- ◆ **Other Abuse:** If I have reasonable cause to believe that other forms of abuse have occurred, I may have an ethical obligation to disclose PHI in order to prevent harm to my patients and others. I will use my professional judgment to determine whether it is appropriate to disclose PHI.
- ◆ **Clear and Immediate Danger:** If I believe that there is a clear and immediate danger to others or society, I may report relevant information to the appropriate authorities.
- ◆ **Future Crimes:** If I believe there is a clear and serious intent to commit a future crime involving physical injury, threat to physical safety of anyone, sexual abuse, or death; and if I believe there is a danger of the crime being committed; then I may report information to the authorities.
- ◆ **Medical Emergency:** I may disclose PHI that would facilitate treatment in the case of a medical emergency or involuntary commitment. This includes situations in which a person poses a danger to self or others. Such disclosures may also be covered under HIPAA.
- ◆ **Legal Proceedings and Court Orders:** I may have to release your PHI if (1) you become involved in a lawsuit and your mental or emotional condition is an element of your claim, or (2) a court orders your PHI to be released or orders your mental evaluation.
- ◆ **Worker’s Compensation Claim:** If you file a Worker’s Compensation claim, this

authorizes me to release all relevant records to involved parties and officials. This includes any past history of complaints or treatment of conditions similar to those involved in the claim.

- ◆ **Legal Defense:** If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- ◆ **Government Health Oversight:** If the Oregon State Board of Psychologist Examiners or a government agency requests PHI for health oversight activities, I may be required to provide it.

While this summary of the exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In specific situations, formal legal advice may be needed.

Patient's Rights

HIPAA provides you with the following rights with regard to your Clinical Record and disclosures of your Protected Health Information. I will be happy to discuss any of these rights with you upon request. Should you wish to utilize any of these rights, please make your request in writing. If necessary, I can provide you with the proper form or procedure.

- ◆ **Right to Request Restrictions:** You have the right to request restrictions on the uses and disclosures of your PHI. However, I am not required to agree to a restriction that you request.
- ◆ **Right to Receive Confidential Communications:** You have the right to request that I communicate with you in certain ways or at certain locations. For example, you can ask that I only contact you at work or by mail. All reasonable requests will be accommodated.
- ◆ **Right to Inspect Records:** You have the right to inspect and/or receive a paper copy of your PHI in my mental health and billing records for as long as the PHI is maintained in the record. You may be charged a copying/printing fee of \$30 for the first ten pages, 50¢ per page up to 50 pages, and 25¢ per page for over 50 pages, plus any postage. I may deny access to PHI under certain circumstances and in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- ◆ **Right to Amend:** You have the right to request an amendment of your PHI for as long as the PHI is maintained in the record. However, I am not required to agree to your amendment. On your request, I will discuss with you the details of the amendment process.
- ◆ **Right to an Accounting:** You have the right to receive an accounting of disclosures of your PHI for which you have neither provided consent nor authorization. I am not required to account for disclosures for treatment, payment, health care operations, or pursuant to an authorization, among other exceptions. On your request, I 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 me upon request, even if you have agreed to receive the NOTICE electronically.

Psychologist's Duties

- ◆ I have a legal duty to maintain the privacy of your PHI.
- ◆ I will abide by the terms of the current NOTICE.
- ◆ I will not disclose your PHI for any other purpose without your AUTHORIZATION.
- ◆ I will make sure that all business associates comply with HIPAA regulations and procedures.

- ◆ If I revise the NOTICE, I will post a summary of the revised NOTICE in my office.
- ◆ Upon request, I will provide you with a copy of the current NOTICE.
- ◆ If state or federal law prohibits or further restricts disclosure of your PHI, I will follow the more stringent law.

Complaints

If you believe that your privacy rights have been violated, please contact me immediately, so that we can attempt to address your concerns together. If you are not satisfied with our resolution of your concerns, you may file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. I can provide you with the appropriate form and address upon request, and you will not experience any retaliation from me for filing a complaint.

Effective Date, Restrictions, and Changes to Privacy Practices

The effective date of this NOTICE is located in the bottom right corner of the page. I reserve the right to change the terms of this NOTICE and to make the revised or changed NOTICE effective for all PHI that I maintain, including PHI collected previously. I am not obligated to tell you when the NOTICE has changed, but I will post a summary of the revised NOTICE in my office, with its effective date in the bottom right corner. You are entitled to request and receive a copy of the current NOTICE at any time.

818 COMMERCIAL STREET
SUITE 406
ASTORIA, OREGON 97103



PHONE: 503.550.7873
FAX: 503.406.2297
EMAIL: INFO@DRHEATHERBEE.COM

ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES for Dr. Heather Bee, and I agree to the procedures and policies described therein. Specifically, I agree that my PHI may be used and disclosed by Dr. Bee to carry out treatment, payment, and health care operations as specified in the NOTICE. (For more information on uses and disclosures, please refer to the NOTICE.)

I understand that I have the right to review the NOTICE before signing this consent. I understand that I have the right to request restrictions on the uses and disclosures of my PHI. I also understand that Dr. Bee does not have to agree to my requested restrictions, but if she does agree, that agreement is binding. I understand that I can revoke consent in writing, but I cannot revoke consent retroactively.

Patient (or personal representative)

Signature

Date

Relationship to Patient (if a personal representative)

For Office Use Only

I, Dr. Heather Bee, have attempted to obtain written acknowledgment of receipt of the NOTICE OF PRIVACY PRACTICES from the patient named above, but acknowledgment could not be obtained because:

- The patient or personal representative refused to sign.
- Communications barriers prohibited obtaining the acknowledgment.
- An emergency situation prevented us from obtaining acknowledgment.
- Other (specify below):

Heather A. Bee, Psy.D.

Date