INDIVIDUAL HEALTH CONCERNS

NAME _____ DATE _____

Please check any of the following terms that apply to you under the S=Self or with a family member F=Family

S	F		S	F		S	F	
☐	☐	Depressed mood	☐	☐	Suicidal Thoughts/Plans	☐	☐	Hearing/seeing things others do not
☐	☐	Lost interest or pleasure	☐	☐	Significant ongoing physical pain	☐	☐	Alcohol usage
☐	☐	Lack of energy/fatigue	☐	☐	Stomach problems	☐	☐	Drug usage
☐	☐	Weight gain or loss	☐	☐	Headaches	☐	☐	Gambling Problems
☐	☐	Excessive sleeping	☐	☐	Bowel problems	☐	☐	Pornography use
☐	☐	Difficulty sleeping	☐	☐	Balance problems	☐	☐	Addiction/s
☐	☐	Decreased need for sleep	☐	☐	Seizure problems	☐	☐	Marital problems
☐	☐	Pressure to keep talking	☐	☐	Learning/Academic problems	☐	☐	Divorce
☐	☐	Racing thoughts	☐	☐	Frequent problems with attention	☐	☐	Separation
☐	☐	Excessive risk taking behavior	☐	☐	Stuttering problems	☐	☐	Affair
☐	☐	Panic Attacks	☐	☐	Frequent “on the go” behavior	☐	☐	Problems with ex/spouse
☐	☐	Excessive fear of situation or object	☐	☐	Impulsive behaviors	☐	☐	Parenting problems
☐	☐	Reoccurring thoughts or impulses	☐	☐	Temper	☐	☐	Relationship problems
☐	☐	Repetitive behaviors to reduce stress	☐	☐	Anger	☐	☐	Problems with friends
☐	☐	Witness/experience life threatening event or serious injury	☐	☐	Aggressive behavior toward others	☐	☐	Problems with children
☐	☐	Excessive anxiety or worry	☐	☐	Destructive behaviors	☐	☐	Legal problems
☐	☐	Unable to concentrate	☐	☐	Frequent lying/deceitfulness	☐	☐	Work/job problems
☐	☐	Memory problems	☐	☐	Problems following rules	☐	☐	Financial problems
☐	☐	Memory loss	☐	☐	Sexual problems	☐	☐	School problems
			☐	☐	Eating Problems	☐	☐	Shyness
			☐	☐	Nightmares	☐	☐	Loneliness
						☐	☐	Insecurity
						☐	☐	Isolation

If you have noticed any recent changes in the following areas, please circle those changes.

Vision Hearing Coordination Balance Strength Speech Memory

Thinking Energy Sleeping Menstrual cycle Elimination Eating Sexual activity

List any other medical problems you are experiencing.

_____

_____

List all medications you are taking.

Medication Dose Prescribed by Date prescription started

_____

_____

_____

_____

List any counseling/therapy you or participating family member has received or is receiving.

Therapist Address When Family Member

_____

_____

_____

Have you ever been physically, sexually, emotionally abused? No Yes
If yes, briefly describe:
_____
_____
_____

Have you ever been hospitalized for mental or nervous problems? No Yes
If yes, when and where:
_____
_____
_____

Have you ever attempted suicide? No Yes
If yes, where, when and how many attempts?
_____
_____
_____

Are you suicidal now? No Yes

Do you drink alcohol? No Yes
If yes, what is your typical drink and how often do you drink alcohol?
_____

Age first used alcohol:_____ Age of heaviest/most frequent use:_____ Use in last three months:_____
Have you ever been arrested for driving under the influence (DUI)? No Yes If yes, how many times?_____

Do you use nonprescription/street drugs? No Yes
If yes, what drugs do you use and how often?
_____
_____

Age first used drug(s):_____Age of heaviest/most frequent use:_____Use in last three months:_____

Have you ever been arrested? No Yes
If yes, how many times and for what?_____

Are you currently involved or do you expect to be involved in any court-related matters? No Yes
If yes, please describe:
_____
_____

Do you have any concerns about violence, abuse, alcohol, or drug usage in your family? Please describe:
_____
_____

What additional information would be helpful for me to know? (i.e., illnesses, handicaps, deaths, divorce, school/job changes, suicide) Please describe them:
_____
_____

Your reasons for seeking therapy at this time:
_____
_____

Do you have any goals for therapy? If so, please list:
_____
_____

PATIENT REGISTRATION
(Please Print)

Date _____ Clinician _____

Name _____ Social Security # _____
(Last) (First) (MI)

Date of Birth:_____Age:_____ Sex: ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

Email Address_____

☐ Home Phone (_____) _____ ☐ Work Phone (_____) _____

☐ Mobile/Alt. Phone (_____) _____

Marital Status: ☐ Married ☐ Single ☐ Partner ☐ Divorced ☐ Widowed ☐ Separated

Name of Employer (or School) _____ Grade _____

Student Status: Full-time _____ Emergency Contact name and ph. #: _____
Part-time_____

RESPONSIBLE PARTY

Responsible Party _____ Relationship to Patient _____
(Last) (First) (MI)

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Business Phone (_____) _____

Social Security # _____ Place of Employment _____

If other family members are seen in this office, please list: _____

***** AT THIS TIME A COPY OF YOUR CURRENT INSURANCE CARD AND PHOTO ID IS REQUESTED *****
ALTHOUGH WE TAKE A COPY OF YOUR INSURANCE CARD, WE DO REQUIRE THE FOLLOWING INFORMATION TO BE COMPLETED.

Primary Insurance Company:

Name: _____

Policy # _____ Group # _____

Subscriber Name: _____

DOB _____ SSN _____

Employer: _____

Secondary Insurance Company:

Name: _____

Policy #: _____ Group #:_____

Subscriber Name: _____

DOB: _____ SSN: _____

Employer: _____

My preference for ***automated appointment reminders*** is (please check one):

- ☐ Voice call to Home Telephone Number
- ☐ Voice call to Mobile Telephone Number
- ☐ Text Reminder to Mobile Telephone Number
- ☐ None-I do not wish to get automated reminders

_____

Signature of Patient or Legal Guardian Date

_____

Print Patient Name Print Name of Legal Guardian

Assignment of Insurance Benefits/Release of Medical Information

I authorize Mary Helen Dennihan to release any medical information which may be requested to process claims for payment of medical services through an insurance carrier, prepaid medical plan or a government agency.

I request that payment be made to Mary Helen Dennihan for any bills for service rendered to me by my doctor.

I understand that I am financially responsible to my doctor for any balance not covered by this authorization. I understand that insurance filing is done as a courtesy for the patient and my doctor takes no responsibility for denial or delay of payment.

_____

Responsible Party's Signature Printed Name of Signee Patient Name Date

Informed Consent for Treatment

I give my consent for services for myself or my child/legal dependent with Mary Helen Dennihan and associated members of the professional staff to include evaluation, psychotherapy, medication management, testing (if indicated) and involvement in the treatment planning process. I may at any time decline specific recommendations.

***We reserve the right to discharge any patient from this practice at any time for failure to comply with treatment recommendations or office policy responsibilities. We will suggest referral options in this event.**

_____

Responsible Party's Signature Printed Name of Signee Patient Name Date

Consent to Release Information to Primary Care Physician

Communication between behavioral health providers and your primary care physicians is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary.

I, Do_____/Do Not _____, authorize Mary Helen Dennihan to release information related to my evaluation and treatment to:

Primary Care Physician: _____ Phone: _____

Address:

_____

(Street) (City) (State) (Zip)

_____

Responsible Party's Signature Printed Name of Signee Patient Name Date

If you would like to release medical information to another physician please request a separate release of information form from the receptionist.

Mary Helen Dennihan, LCMFT
8300 College Boulevard, Suite 320
Overland Park, KS. 66210
Direct Line: 913-323-6536 Main Office: 913 338-0400

INFORMED CONSENT & THERAPY CONTRACT

Welcome and thank you for selecting my practice! The following will inform you of the policies and therapy services you will be receiving. Please read and sign the following consent and feel free to ask questions you may have.

1. I understand that I will be working with Mary Helen Dennihan, LCMFT. Mary Helen received her Master's of Science degree in Family Therapy from Friends University. She also holds a bachelor's of Science in Nursing from Avila University. Mary Helen is trained and licensed to provide therapy for individuals, couples, families and groups. She utilizes multiple therapeutic models including, but not limited to EMDR, Systems Perspective, Internal Family Systems, Collaborative, Cognitive Behavioral, Contextual, Solution Focused, Spiritual orientation, and more. Her approaches will depend on the unique needs of each client.
2. I understand that Mary Helen is bound by the **Code of Ethics** set forth by the American Association for Marriage and Family Therapy (AAMFT) and that I can request a copy of these ethics at any time.
3. I understand that as a **client** I have certain **rights** including but not limited to: the right to know my diagnosis and have it explained to me; to assist in planning my treatment, to refuse treatment; to request information on an estimated length of therapy; to request a referral to another therapist; and the right to terminate therapy at any time.
4. I understand that there can be **risks and benefits** associated with therapy. **Risks** may include and are not limited to: experiencing an array of feelings and degrees of discomfort when discovering and talking about various topics, realizing therapy alone may not resolve my problem/s; and not being completely truthful can impede progress. A condition may temporarily worsen before improvement is noted; if I choose to take a break from or terminate therapy during such a time or before the reaching therapy goals, I am accountable for my decision.
5. Examples of **benefits** of therapy include and are not limited to: symptom improvement, enhanced relationships and relational skills, increased knowledge and confidence, expanded problem solving and coping skills, progress towards and/or attainment of treatment goals.
6. Regarding **confidentiality,** I understand that communications with Mary Helen will remain confidential, except under certain circumstances and when mandated by law, as will records regarding the therapy process unless I sign forms authorizing or requesting the release of confidential information and privileged communication. I understand that due to safety, legal or ethical considerations, certain circumstances may require Mary Helen to break confidentiality and report information obtained as a result of the therapy process. Some examples of such circumstances include: a) the therapist believes a client may be a danger to himself, herself, or to others; b) the therapist believes that a child, elderly or disabled person is/was subject to abuse or neglect; and c) when court ordered to provide information regarding the therapy process. Occasionally, or as permitted by law, a need arises to consult with professional colleague/s or referral source on the client's behalf.
7. If more than one **family** member participates in therapy, each participating family member 16 years or older must give written consent prior to the release of that file information. Parents have a right to a reasonable account of their **minor child's therapy**. Mary Helen works to involve parents in the treatment of a minor child. On occasions a minor child reveals information in therapy that they wish to remain confidential. Mary Helen will typically honor the minor's request and will also consider ethical and clinical concerns.
8. When **couples** are receiving conjoint counseling only, individual's confidences received outside of these sessions will typically not be held from one partner and will be discussed in session unless otherwise specified and reasons made clear. The decision remains at the therapist's discretion.
9. I understand that in the State of Kansas, Mary Helen may consult with my primary care physician or psychiatrist to determine if there may be a medical condition or medication that is contributing to symptoms of a mental

disorder. I also understand that I may waive this consultation in writing and that my therapist will discuss this process with me at any time I so request.

10. **Financial Policy:** Each appointment will be 50 minutes. The first session will be $125.00; subsequent sessions will be $100.00. Sessions that go 53 minutes or longer will be billed additionally on the quarterly hour rate. I understand that I am responsible for my balance, co-pays, deductibles, and non covered services. The office staff will file participating insurance claims, or I can file my own claims. A **self pay discount** is available for all who pay the total amount at the time services are rendered. Mary Helen will discuss applicable rates with me should I request. The office reserves the right to send an account to collections if not paid within 60-90 days.
11. The person/parent who brings a **minor** for care is responsible for their bill.
12. **Missed appointments** with less than 24 hour notice, will be charged a minimum of 50% of the regular session fee; each additional missed appointment will be charged up to 100% of the visit charge. Insurance companies do not pay for missed appointments. More than 2 missed appointments with less than 24 hour notice may result in termination of services.
13. **Occasional phone calls, letters, and emails** to/from me on my behalf, will be a complimentary part of my service. Frequent and those 10 minutes and over will be charged based on ¼ hours of my session rate.
14. There will be **additional charges** for cases that are/will be **court/legally involved**. Charges for all additional letters, emails, telephone calls, faxes, reports, other communications/services, and court proceedings, including travel, wait and court appearance time will be based on a **minimum** of $150.00 per hour rate.
15. **A 24 hour phone line** is available for messages at 913-338-0400 or 913-323-6536. For emergencies please call your psychiatrist, family doctor, 911 or go to an Emergency Department. Messages sent to my personal phone number or email account are not assured of confidentiality. Please only leave information on the numbers listed. Thank you.
16. I give permission to Mary Helen and staff to **receive, call and leave information** regarding scheduling, treatment, or other information as necessary on my home, cell, or designated phone, answering machine, voicemail or with a live person answering the phone, and to **send written information** to address on record.
17. I give Mary Helen **permission to release health information** acquired in the course of my treatment or assessment process to my insurance company, worker's compensation, employee assistance programs, disability requests, prepaid medical plan or government agency for billing purposes.
18. I give permission to Mary Helen to write/thank the person/agency that referred me to her practice.

My signature below indicates that I understand and agree with the therapist's policies and I give my full and informed consent to receive individual, couple, family, and/or group therapy services from Mary Helen Dennihan M.S., LCMFT.

_____

Client Signature Date

_____Client Signature Date

_____

Therapist Signature Date

FAMILY INFORMATION

Date:

Name	Date of Birth	Soc. Sec. #
Address Email		Home Phone Cell Phone
Employer		Office Phone
Spouse's Name	Date of Birth	Soc. Sec. #
Address		Home Phone
Spouse's Employer		Office Phone
Person Responsible for Payment		Relationship
Address		Home Phone
Employer		Work Phone

Please list any additional family members living with you:

Name	Relationship	DOB

List family physician information below:

Physician	Phone #
Address	
Other Physician(s)	Phone #
Address	

MARY HELEN DENNIHAN, MS, LCMFT
AUTHORIZATION & REQUEST FOR RELEASE OF
CONFIDENTIAL INFORMATION AND PRIVILEGED COMMUNICATION

In accord with my legal right to confidentiality and privileged communication relevant to the services that I have received, I authorize and request the disclosure of confidential information ***from Mary Helen Dennihan, to the following individual(s)/agency*** and the release of confidential information by ***the following individuals(s)/agency to Mary Helen Dennihan:***

To be Completed by Therapist:

Agency/Name:	
Address:	
Phone:	Fax:

To be Completed by Client:

PRINTED Name of Client/Family:	DOB:
Address:	Phone:

The client will indicate and initial their choice(s) of release listed below:

_____a. Summary report of services received
_____b. Consultation and/or verbal communication between above named parties
_____c. Any and all records pertaining to services received
_____d. Other

It is my understanding that this information will be used for

_____
_____

This consent expires _____, unless revoked by me in writing at an earlier time.

I issue this authorization with knowledge of the contents of the material or communication and understanding of the consequences, and do so voluntarily and free from duress or undue influence.

In accordance with federal regulations (42 CFR Part 2), which prohibit any further disclosure of this information, except with specific written consent of the person to whom it pertains, redisclosure of this information is prohibited.

I agree to pay a reasonable fee, if any, for the preparation of the materials and hereby hold harmless the above-named practitioner from any liability relevant to the release of the confidential information or privileged communication.

I understand that the person(s) named as following participated in the therapy and must sign a request for release before any information in this file may be released:

_____ _____
_____ _____

Printed Name of Client	Client Signature	Date
Therapist		Date

MARY HELEN DENNIHAN MS, LCMFT

MINOR CONSENT

Date:_____

This is to certify that I/we,_____, have legal custody or guardianship of the following child or children and have the legal right to authorize the care, treatment and counsel of this/these child(ren):

Name of Child	Date of Birth

And give consent for him/her/them to receive individual and/or family therapy from Mary Helen Dennihan.

Legal Custodial Parent/Guardian Signature	Date	Legal Custodial Parent/Guardian Signature	Date
Therapist Signature	Date		

Mary Helen Dennihan, MS, LCMFT

NOTICE OF PRIVACY PRACTICES

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

Mary Helen Dennihan is committed to protecting your personal health information. If at any time you have any questions or concerns about how your confidential information is being used you are encouraged to notify the practice staff so that appropriate personnel can quickly address and resolve these concerns.

Effective Date: April 13, 2003
This Notice was revised on July 30, 2018.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer:	Jane Freeman
Mailing Address:	8300 College Blvd, Suite 320, Overland Park, KS 66210
Telephone:	(913)338-0400
Fax:	(913)338-0428

About This Notice
We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?
"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information
We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities

that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

- **Research**. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

- **As Required by Law.** We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others, but we will only disclose the information to someone who may be able to help prevent the threat.

- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to

protect the privacy and ensure the security of your Protected Health Information.

- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

- **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

- **Fundraising Activities.** We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures of Protected Health Information for marketing purposes; and
3. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization, but disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional chosen by KCPG who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agrees to this alternative form and pay the associated fees.

- **Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

- **Right to Request Amendments.** If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for

electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.

- **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.