PATIENT REGISTRATION

Date _____ Parent/Legal Guardian Name (who filled out form): _____

Name _____ Social Security # _____
First, MI, Las

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 Jacque 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 Jacque 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 Jacque 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 Jacque 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.

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ Date: _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks* how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐	☐	☐	☐

Jacque Dennihan, MS, LCMFT
8300 College Boulevard, Suite 320
Overland Park, KS 66210
(913) 338-0400

Informed Consent and Therapy Contract

Welcome! Please thoroughly review this document, which is intended to provide important information regarding your treatment as well as your client rights and responsibilities. This documentation also outlines my office policies. While reviewing this document in its entirety, please direct any questions to me related to its content.

1. I understand that therapy services will be provided by Jacque Dennihan, MS, LCMFT. Jacque obtained her Masters of Science in Family Therapy from Friends University. Jacque is trained and clinically licensed to provide therapy for individuals, families, couples, and groups. Jacque utilizes multiple therapeutic modalities including, but not limited to: Systems Theory Therapy, Emotion Focused Therapy, and EMDR (Eye Movement Desensitization and Reprocessing). Jacque utilizes and emphasizes themes of trauma informed care, self-compassion, and mindfulness in her work with clients. I understand that I am free at any time to offer further inquiry related to Jacque's clinical experience and professional orientation.
2. I understand that Jacque is bound by the Code of Ethics set forth by the American Association for Marriage and Family Therapy (AAMFT). I understand that I can request a copy of these ethics at any time.
3. I understand that confidentiality is important to the therapeutic process, and proper actions are taken to ensure that therapeutic communications and client records remain confidential, unless I offer written permission to release information. There are exceptions and limits of confidentiality, however, and it may be required by law to release information without my consent. Limits of confidentiality include, but are not limited to: when a therapist believes that a client may represent a danger to themself and/or other(s), when a therapist believes that a child, elderly, or disabled person is/was subject to abuse and/or neglect, when the court orders release of information, or in the event of a medical emergency. Occasionally, or as permitted by law, a need arises to consult with professional colleagues in order to best serve a client. I understand that recording during sessions is prohibited.
4. I understand that communications between therapists and clients that are minors (under the age of 18) are confidential, however, parents and other guardians who provide authorization for their child's treatment are often involved in their child's treatment. Jacque, in the exercise of her professional judgement, may discuss the treatment progress of a minor patient with the parent or caregiver. On occasion, a minor child may reveal information in therapy that they wish to remain confidential. I understand that Jacque may honor the minor's request, while also considering ethical and clinical concerns. Patients who are minors and their parents/caregiver(s) are encouraged to discuss any questions or concerns that they have related to this topic. I understand that should a minor client be under the age of 14 years old, at least one parent and/or legal guardian must be present for the initial therapy appointment. Parent(s) and/or legal guardians of minor clients over the age of 14 are also encouraged to be present for the initial therapy appointment.
5. I understand that I have client rights. Client rights include, but are not limited to: receiving information regarding the qualifications and clinical experience of my therapist, participating in the planning of my treatment, receiving an explanation of my diagnosis should this apply, having my clinical records kept confidential to the extent permitted by law, exhibiting my right to terminate therapy services at any time and/or request a referral for another therapist. I understand that I have the right to receive treatment regardless of age, race, ethnicity, gender, gender identify, sexual orientation, disability, and religion/spiritual affiliation.
6. I understand that there may be risks and/or benefits associated with participating in therapy services. Potential risks may include, but are not limited to: the experience of uncomfortable emotions and/or thoughts while processing regarding difficult events, the experience of a condition temporarily

worsening before improvement is observed, or the experience of challenging therapeutic dialogue with therapist and/or family members. Oftentimes, individual and/or family dynamics may change as a result of individual and/or relational growth and there can be challenge associated with this change. Potential benefits may include, but are not limited to: gained intrapersonal (within the self) or interpersonal (relational) insight, decreased symptomology and/or increased ability to manage experiences of suffering, increased ability to exhibit effective relational skills and/or problem solving skills, improved relationships with self and/or others, and the experience of overall healing. I understand that that my active participation and compliance will be an important in achieving positive outcomes.

7. I understand that it is my therapist's intention to provide services that will assist in reaching my individual and/or relational goals. I understand that Jacque and I will develop a treatment plan, outlining goals/objectives to work towards achieving while participating in therapy services. I understand that Jacque may periodically provide feedback regarding my progress in treatment and will invite my participation in this discussion. It is the goal of my therapist to assist in effectively addressing individual and/or relational challenges brought forward within therapeutic dialogue. However, due to the varying nature and severity of challenges and the individuality of each client, my therapist is unable to predict the length of therapy and/or to guarantee a specific outcome of result.
8. I understand that when participating in couples or family therapy, the couple or whole family unit is considered to be the client. I understand that Jacque may meet with an individual family member and/or a smaller part of the treatment unit for one or more sessions. These sessions should be viewed as a part of the work that I am doing with my family unit or my partner. I understand that individual confidences disclosed within an individual meeting will typically not be held from partners or family members and will be discussed in family therapy session(s) unless otherwise specified and reasons made clear. This decision remains at my therapist's discretion.
9. I understand that the standard fee for an initial appointment is $140.00 and the standard fee for remaining appointments is $125.00. For clients who pay privately or have out-of-network benefits, payment is due at the time services are rendered. Self-pay clients are eligible for a 20% discount, should services be paid in full at the time of the scheduled session. When a minor(s) client is participating in treatment, the parent/caregiver who brings the minor(s) for care is responsible for payment compliance. Office staff will assist in filing participating insurance claims, or I can choose to file my own claims. I understand that I am responsible for my balance, co-pays, deductibles, and non-covered services. The office reserves the right to send an account to collections should payment not be received within 60-90 days of scheduled appointment.
10. I understand that scheduled appointments will be approximately 50 minutes in duration. There may be times that an urgent matter and/or a client emergency arises with another client prior to my scheduled appointment. Should this occur, my therapist will be with me as soon as situation allows.
11. I understand that if I am utilizing insurance or third party payment benefits for therapy services, I (individual therapy services) my minor child (individual therapy services of a minor child), or the identified and/or insured family member (family therapy services) will receive a mental health diagnosis in order to code for billing.
12. Please call the main office at (913) 338-0400 in order to schedule, change, or cancel therapy appointments. In order to cancel or reschedule an appointment, I understand that I am expected to notify my therapist at least 24 hours in advance of my scheduled appointment time. I understand that the first missed and/or cancelled appointment with less than 24 hour notice will be charged a minimum of 50% of the session rate. Subsequent missed and/or cancelled appointments within 24 hours or less will be charged 100% of the session rate. I understand that my insurance company will not pay for missed or cancelled appointments. I understand that two or more missed appointments with less than 24 hour notice may result in termination of services.
13. I understand that occasional brief phone calls, to/from me on my behalf, will be a complimentary part of my therapist's service. However, extended therapeutic dialogue via phone will be billed per 10 minute segments. I understand that the charge for extended therapeutic dialogue via phone will be $15.00 per 10 minutes.
14. A 24 hour phone line is available for messages at 913-338-0400. In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to

request emergency assistance or go to a local Emergency Department. I understand that Jacque can provide me with a list of local community resources that are available to assist individuals who are in crises, upon request.

15. I give Jacque Dennihan, MS, LCMFT permission to release health information acquired in the course of my assessment or treatment process to my insurance company, worker's compensation, employee assistance programs, disability requests, prepaid medical plan or government agency for billing purposes.
16. I give permission to Jacque Dennihan, MS, LCMFT and staff to receive, call and leave information regarding scheduling, treatment, or other information as necessary on my home, cell, or designated phone, voicemail or with a live person answering the phone, and to send written information to my address on record. Should my contact information change, I understand that I am to report these changes to my therapist, in order to ensure continuity of care.
17. I understand that my therapist maintains record of scheduled appointments and correspondence between scheduled appointments, including correspondence via electronic communication. Such records include, but are not limited to: date/time of scheduled appointments and correspondence, types of services and/or communications provided, questionnaires and/or assessments provided, recommendations provided, a plan for service delivery, and information pertaining to correspondence via electronic communication.
18. I understand that any information I would like forwarded to another provider, school, attorney, employer, etc. requires a signed Release of Information. I understand that I must provide my therapist at least 72 hours for any letters and form completion. I understand that there may be a fee associated with the preparing of materials.
19. I understand that additional charges will apply for cases that are/will be court/legally involved. Charges of $200.00 per hour will be applied for all record review and submission, completion of reports, email and telephone correspondence with necessary professionals, as well as other communications/services. Charges of $200.00 per hour will also be applied for therapist participation in court proceedings, including travel, wait time, and court appearance time.

My signature below indicates that I have read this agreement for services, understand and agree with its content, and give my full and informed consent to receive individual, family, couple and/or group therapy services from Jacque Dennihan, MS, LCMFT.

_____

Client/Guardian Signature Date

Consent for Treatment

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to and authorizes services by Jacque Dennihan, MS, LCMFT. These services may include psychotherapy and other appropriate alternative therapies.

The undersigned understands that he/she/they has the right to:

1. Be informed of and to participate in the selection of treatment services.
2. Receive a copy of this consent upon request.
3. Withdraw this consent at any time.
4. Be referred to another professional if requested.

_____

Signature of Patient or Legal Guardian Date

Consent for Treatment of a Minor

This is to certify 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

I/we give consent for him/her/them to receive individual and/or family therapy services from Jacque Dennihan, MS, LCMFT.

_____

Legal Custodial Parent/Guardian Signature Date

Authorization for Electronic Communications

I understand that I may choose to utilize technology in and/or between scheduled counseling appointments, in order to communicate with Jacque Dennihan, MS, LCMT regarding my treatment- or the treatment of my minor child- via email and/or text message. I understand that I am responsible for ensuring the confidentiality of the location in which I speak on the phone with my therapist, schedule appointments, email, or text.

I understand that, upon my signed consent below, Jacque Dennihan, MS, LCMFT may transmit my protected health information- or that of my minor child- via electronic communications. Such information may include, but is not limited to: information pertaining to appointments, diagnosis, treatment planning, treatment interventions, and additional information regarding the overall treatment process. I understand that there are risks associated with transmitting protected health information via electronic means including, but not limited to: electronic information being delayed, lost, altered, or accessed by unauthorized person(s).

I understand that I may refuse to sign this authorization. I understand that I have the right to revoke this authorization at any time by submitting written notice to jdennihan@kcpsych.com. Should I revoke this authorization in the future, I understand that the revocation does not apply to information that was previously released as a result of signing this authorization.

My signature below indicates that I understand the risks associated with transmitting protected health information and I authorize Jacque Dennihan, MS, LCMFT to engage in the electronic and internet communication described above. I hereby release Jacque Dennihan, MS, LCMFT from any liability that may arise from the release of electronic information.

_____

Signature of Patient or Legal Guardian Date

Telehealth Informed Consent

I understand that telehealth services are a means of delivering health care services, including therapy, via communication technologies (i.e. Internet or phone) in order to facilitate treatment and care management.

I understand that confidentiality is important to the therapeutic process, and proper actions are taken to ensure that therapeutic communications remain confidential whether therapy services are conducted in-person or via telehealth services. The limits of confidentiality outlined in the Informed Consent and Therapy Contract apply whether therapy services are conducted in-person or via telehealth services.

I understand that there are risks associated with participating in telehealth services including, but not limited to: transmission of treatment information being disrupted by technical difficulties and/or therapy sessions being accessed by unauthorized person(s). I understand that I am responsible for ensuring the confidentiality of the location in which I and/or my minor child choose to engage in telehealth appointments.

I understand that therapy services provided via telehealth may or may not be as effective or provide the same results as in-person therapy. I understand that my therapist is willing to engage in dialogue regarding the possibility of meeting in-person and/or referring to in-person therapy services, should I and/or she feel that in-person therapy is imperative to supporting my mental health and/or that of my minor child.

I understand that some telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record therapy sessions without the other party's written consent.

My signature below indicates that I have read this documentation in its entirety and understand and agree with its content. I understand that I have the right to have any inquiries regarding this information answered.

_____

Signature of Patient or Legal Guardian Date

Client Intake Questionnaire

Review and answer the following questions and statements. Leave blank any questions and statements that you would prefer not to answer, do not know how to answer, or would prefer to discuss during a scheduled appointment.

Name:_____ Date: _____

Presenting Concerns and Goals of Treatment

Describe your reasons for seeking individual or family therapy services at this time.

_____
_____
_____
_____

Describe concerns or problems that you hope to resolve as a result of attending individual or family therapy services and/or what you hope to achieve or gain as a result of attending individual or family therapy services.

_____
_____
_____
_____

Age, Gender, Sexual Orientation

Age: _____

Gender Identity: _____

Sex assigned at birth:_____

Sexual Orientation: _____

Cultural and Spiritual Considerations

Share information related to meaningful cultural, religious and/or spiritual practices, or important aspects of your background or identity. Describe how gender, ethnicity/cultural/tribal affiliations, and religious and/or spiritual affiliations are likely to impact your treatment.

_____
_____
_____
_____

Mental Health History

Often, people look for help from different sources, including different kinds of doctors, therapists, helpers, or healers. In the past/present, what kinds of treatment, help, advice, or healing have your sought related to any mental health struggles or symptoms? Describe past/present mental health treatment you have received and/or are receiving and include approximate dates of treatment.

Have you been admitted to the hospital to address mental health symptoms? If so, describe reason for hospitalization and include approximate dates of treatment.

Any history of thoughts, plans, intentions, or attempts of suicide? If so, please describe.

Any history of thoughts, plans, intentions, or attempts of homicide? If so, please describe.

Any additional immediate risks, including but not limited to self-harm, threats from another person, critical medical condition(s)? If so, please describe.

Describe current mental health symptoms and/or present stressors. Identify any past/present mental health diagnosis that you have received, should this apply.

List medications that you are prescribed in order to address mental health symptoms, should this apply.

Physical Health History/Medical Information

Describe current physical health concerns and identify any present diagnosis that you have received.

List medications that you are prescribed to address physical health symptoms, should this apply.

Substance Use History

Describe past and/or present substance use including substance(s) used, method or route of administration, age of first use, age of heaviest use.

Describe past/present treatment that you have received and/or are receiving to address a Substance Use Disorder and include approximate dates of treatment. Include specific types of treatment or support (i.e. residential treatment, outpatient treatment, or community/group support such as Narcotics Anonymous or Alcoholics Anonymous).

Education and Employment Information

Describe education history and/or present schooling experience.

Describe present employment. Describe current source(s) of income (i.e. employment, unemployment benefits, spouse/significant other, Social Security, Short-term Disability etc.)

Legal History

Are you currently involved or do you expect to be involved in any court-related matters? If so, please describe. Describe past legal involvement (i.e. previous arrests, incarceration, involvement in probation), should this apply.

Jacque Dennihan, 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.

Jacque 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.