HARMONY UNITED PSYCHIATRIC CARE

New Client (Patient)_Information

MINOR OR ADULT GUARDIAN

Client Information

Last Name : ____________________________________

First Name : ____________________________________

Date of Birth : ____________________________________

Sex: Male ___ Female ___ Other: _____________

Marital Status : ____________________

Race: _____________________

Ethnicity: ____________________________________

Social Security Number : ____________________

Street Address: ____

City : ____________________________ State : _________ Zip : ______________________

Cell (Required): ________________________ Home Phone : _________________________

Email : ____

Emergency Contact Information

Name: ___________________________________ Relationship: _______________________________

Cell Phone: ___________________________________

Reference Information

How did you hear about us?

Physician Referral _____

Insurance Referral _____

Friend / Personal Referral _____

Google _____

Facebook _____

Other Social media sites ____

Physician directories ____

Print media (newspaper, magazine) _______________________________________

Insurance Information

Primary : ___________________ **Policy #** ____

Subscriber : ___________________ Relationship to Client: ________________________________

Date of Birth : ___________________

Employer of Policy Holder: ____

Secondary Insurance Policy: ______________________ **Policy Number:** ______________________

Subscriber : ___________________ Relationship to Client: ________________________________

Employer of Policy Holder: ____

Primary Care Physician Information

Primary Care Physician :

____

Phone : ____________________________ Fax: __________________________

Address : ____

City : ___________________________ State: ________ Zip: ___________

Pharmacy Information

Pharmacy Name : ____

Street Address : ____

City : _____________________________________ State:_________ Zip Code : ______________

Phone : ____

Medication List (medications you are currently taking)**:**

Name of Medication	Dosage	Frequency
(Zoloft, Lisinopril)	(50mg or 10ml)	(once a day, twice a day, etc.)

____

____

____

____

____

____

Acknowledgement of Receipt of Office Policies

I have received a copy of and read the Office Policies and I am aware of the service charges that Client will incur for appointments that are missed or appointments that are cancelled less than 24 hours before a scheduled appointment OR less than 48 hours (or 2 business days) prior to a scheduled Neuropsychological Testing appointment.

I understand that failure to comply with these policies may result in termination of my care. I understand and accept that these policies are subject to change from time to time. It is my responsibility to obtain most up to date office policies and/or to make myself aware of the current policies in the lobby area of offices of Harmony United Psychiatric Care.

I understand and accept the Office Policies. Furthermore, I also accept that I will make myself aware of updates to office policies in the future.

Initials of Parent / Guardian: ______________________

Acknowledgement of Receipt/Location of Notice of Privacy Practices

I acknowledge that I have read the Provider's Notice of Privacy Practices and I have been made aware of the availability of notice in the offices of Harmony United Psychiatric Care.

I understand and accept the acknowledgement of receipt of notice of Provider's Notice of Privacy Practices.

Initials of Parent / Guardian: __________________

Release of Information for Emergency Purposes

I give my consent to Harmony United Psychiatric Care to release information on an emergency basis only to the following people.

If you do not agree to this Release of Information for Emergency Purposes, please:

Initial here ➧: __________

Please print the full legal name and relationship to Client.

1. ________________________ ________________________
   Print Full Name Relationship

   ________________________ ________________________
   Cell Phone Number Email

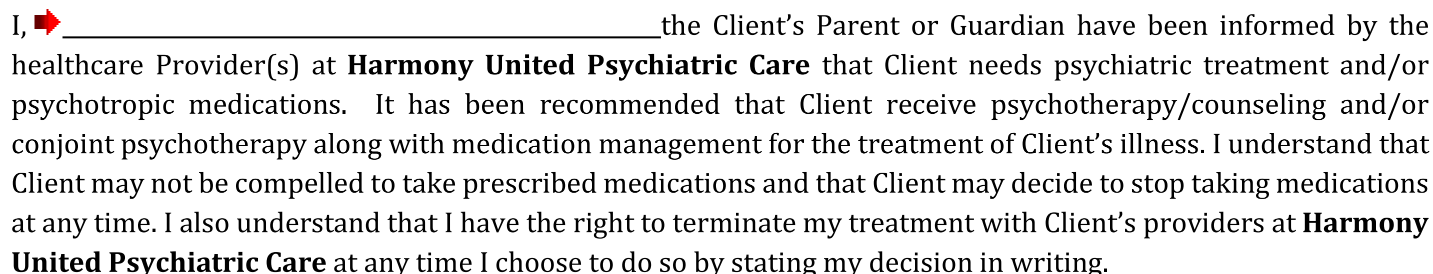
2. ________________________ ________________________
   Print Full Name Relationship

   ________________________ ________________________
   Cell Phone Number Email

I understand and consent to this Release of Information for Emergency Purposes to the above stated individuals.

Initials of Parent / Guardian: ➧________________

Consent for Treatment / Medication



I, ➡ ______________________________ the Client's Parent or Guardian have been informed by the healthcare Provider(s) at **Harmony United Psychiatric Care** that Client needs psychiatric treatment and/or psychotropic medications. It has been recommended that Client receive psychotherapy/counseling and/or conjoint psychotherapy along with medication management for the treatment of Client's illness. I understand that Client may not be compelled to take prescribed medications and that Client may decide to stop taking medications at any time. I also understand that I have the right to terminate my treatment with Client's providers at **Harmony United Psychiatric Care** at any time I choose to do so by stating my decision in writing.

I understand that it is my responsibility to inform Client's healthcare provider(s) of Client's medical and psychiatric background. I understand that refusal to abide by prescribed treatment (e.g.: not taking or overtaking prescribed medications, missing or rescheduling appointments repeatedly, etc.) is a basis for termination of care due to noncompliance. I also understand that although the healthcare provider(s) at **Harmony United Psychiatric Care** believe this treatment will be of benefit to Client, there is no guarantee as to the results that may be expected.

With this understanding, I authorize my healthcare provider(s) at **Harmony United Psychiatric Care** to render the necessary psychiatric services as deemed advisable, including but not limited to psychiatric medication management, psychotherapy/counseling, neuropsychological testing, etc. I also consent to psychotropic medications prescribed to Client and I will discuss the side effects of the medications prescribed to Client with the healthcare provider.

I understand and consent for this Treatment/Medication.

Initials of Parent / Guardian: ➡ ______________

Consent for Telehealth

Telehealth technology is currently being utilized to provide health care services nationally and in Florida. Telehealth technology can enable real-time communication between patients and health care providers using live video conferencing; and, can securely store-and-forward clinical data to offsite locations for evaluation by health care providers.

The United States Department of Health and Human Services notes that Telehealth is not a type of health care service but is rather a means or method used to deliver health care services.

As with in-office visits ➡ I, ____ the Client's Parent or Guardian, understand that Client is expected to abide by treatment prescribed by his/her providers at **Harmony United Psychiatric Care**. I understand that Client's refusal to abide by the prescribed treatment (e.g.: not taking or overtaking prescribed medications, missing or rescheduling telehealth appointments repeatedly, etc.) delivered through Telehealth technology is a basis for termination of care due to noncompliance. I also understand that although the healthcare providers at **Harmony United Psychiatric Care** believe this treatment will be of benefit to Client, there is no guarantee as to the results that may be expected.

With these understandings, I authorize Client's healthcare provider(s) at **Harmony United Psychiatric Care** to render the necessary psychiatric services through Telehealth technology, including but not limited to psychiatric medication management, psychotherapy/ counseling, etc. Further, I agree that this Consent does not supersede or replace my Consent for Treatment for in-office services.

I, ➡____, the Client's Parent or Guardian, consent to have Client's treatment delivered through Telehealth technology. **If I elect to not sign this consent, Client will not be eligible to receive treatment via Telehealth technology.**

Sign: ____ Date:__________________

Consent for Insurance Filing

Insurance Release: I authorize the release of any information the Provider may feel necessary to process Client's insurance claims, and I authorize payment of benefits directly to Client's Provider of services, and I fully understand that I am responsible for any portion of my bill not covered by the insurance company including but not limited to co-payments, deductibles, etc.

I understand and consent for insurance filing.

Initials of Parent / Guardian: ➡ ________________

Consent to Receive Marketing Information from Harmony United Psychiatric Care

I consent to receive information (including unsolicited marketing information) from Harmony United Psychiatric Care about new products or services, or general medical information.

I consent to receive information via my (please check):

Email: ________

Text to my Cell Phone ________

Direct Mail ________

I understand I may opt-out of this Consent at any time by notifying Harmony United Psychiatric Care.

Initials of Parent / Guardian: ➡ ________________

Consent to Receive Communication

From Harmony United Psychiatric Care

I consent to receive communication from Harmony United Psychiatric Care regarding any upcoming appointments.

I consent to receive information via (please check):

Email: ___________________________________

Text to my Cell Phone: ______________________

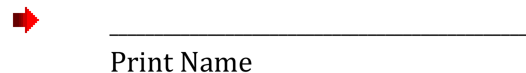
Phone call: _________________________________

Initials of Parent / Guardian: __________________

Acknowledgement

I acknowledge that I have read, fully understand, and accept the above documents.

____________________________________ ____________________
Signature of the Parent or Guardian Date


____
Print Name

New Patient Questionnaire

All Answers Are Confidential!

PLEASE COMPLETE THE PHQ-9 FORM (FOR AN ADULT AGE 20 AND OVER) LOCATED AT THE END OF THIS NEW PATIENT PAPERWORK PACKAGE

OR

PLEASE COMPLETE THE PHQ-A FORM (FOR AN ADOLESCENT BETWEEN THE AGE OF 12 AND 19) LOCATED AT THE END OF THIS NEW PATIENT PAPERWORK PACKAGE

What is the reason for Client's visit to the clinic? [Chief Complaint(s)]

____

____

____

Has Client ever had any Psychiatric admissions to an inpatient unit? Yes / No

If yes, then, how many total admissions? (e.g.: 1, 2, 5 or more than 5): ________________________

Last Admission (e.g. in Nov 2015, Jan 2010 or just 2015 or 2010):

____

Past suicide attempts? Yes / No

If yes, then, how many suicide attempts (actual harm to self not just thoughts) _________________

Last suicide attempt and method of suicide attempt (e.g. Nov 2015, overdose on medication):

____

Has Client in the past or is currently seeing a psychiatrist or therapist? Yes / No

(e.g. Was seeing a psychiatrist 'Dr. Clark' for 3 years, last saw 1 year ago, was seeing a therapist Mr. John Doe, or Client is currently seeing a psychiatrist 'Dr. Johnson' for 5 years)

____

____

Current or past treatment for substance abuse? Inpatient or Outpatient detox/ rehab:

____

Client Medical Problems: (Medical Diagnoses)

____

____

____

____

Client's Psychiatric Problems: (Mental Health Diagnoses)

____

____

____

____

____

Client's Allergies to Medication(s) or non-medication (food, pollen, etc.):

____

____

____

How was Client's growth and development as compared to his or her peers as a child?

- ☐ Normal
- ☐ Abnormal

If Abnormal, please explain:____

____

Where was Client born and raised : ___________________________

Who raised Client as a child : ___________________________

In one word, how would Client describe his/her childhood experience?

GOOD BAD TRAUMATIC PLEASANT UNPLEASANT DIFFICULT FAIR

PLEASE SPECIFY: ____

____

Have Client ever been abused? No _______ Yes _______

PHYSICAL SEXUAL EMOTIONAL

IF YES, PLEASE SPECIFY:

____

____

____

What is Client's highest completed level of education: ___________________________

Client's Employment status:

EMPLOYED UNEMPLOYED DISABLED RETIRED

If employed, please specify profession:

____

Sexual Orientation:

Heterosexual ______ Homosexual _______ Bisexual______ Other: ____________________

Marital Status:

MARRIED WIDOWED SINGLE IN A RELATIONSHIP DIVORCED SEPARATED

How many children? ______________

Who does Client live with OR lives with Client? ____

How does Client support himself/herself financially? ____

Who does Client consider as emotional support? ____

Is Client currently using any illicit drugs or Alcohol? Yes / No

ALCOHOL ___ COCAINE ______ MARIJUANA ______ HEROIN _______ OTHER_________

If yes, please specify the quantity, frequency and how long has Client been using Drug(s)/Alcohol. (ex: *5-6 beers, daily, for 20 years*)

____

____

Has Client in the *past* used any illicit drugs or abused alcohol? Yes / No

If yes, please specify:

____

____

Is Client a Tobacco or Tobacco product user? Yes ______ No _______

Does anyone in Client's immediate family (e.g.: father/mother/siblings) have a history of mental illness, suicide (attempted or completed), or substance abuse? Please Specify:

____

____

Any arrests or incarcerations? When and Why?

____

____

Currently on probation or parole? If yes, specify the duration for probation/parole.

____

Has Client served in the military? No _______ Yes ________

If yes, then number of years served: _________________________

Type of discharge: ____

____

Financial Agreement

1. FINANCIAL AGREEMENT

The undersigned agrees as the agent of Client/Patient, that in consideration of the services to be rendered to the Client/Patient, he or she individually obligates himself or herself to pay the account of Harmony United Healthcare and Research, P.A. d/b/a Harmony United Psychiatric Care ("Harmony") in accordance with the regular rates and terms of Harmony. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the current FL legal rate of 9.0%.

2. ASSIGNMENT OF INSURANCE BENEFITS

The undersigned authorizes the direct payment to Harmony of any insurance benefits otherwise payable to or on behalf of the undersigned for this treatment, including emergency services if rendered, at a rate not to exceed the Harmony's regular charges. It is agreed that payment to Harmony, pursuant to this authorization, by an insurance company shall discharge such company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he or she is financially responsible for charges not covered by the assignment.

3. HEALTH CARE SERVICE PLAN OBLIGATION

Harmony maintains a list of health service plans with which it has contracted. A list of such plans is available on request. Harmony has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees that he or she is individually obligated to pay the full costs of all services rendered to him or her by Harmony if he or she belongs to a plan which does not appear on the above-mentioned list. **Please read and respond to the following statements regarding advance directives, durable power of attorney for health care or living will:**

Please Confirm:

☐ I have received information about my right to make decisions regarding Client's medical treatment, my right to formulate advance directives in the case of Client's subsequent incompetency and Harmony's policies on the implementation of these rights.

Does Client have an Advance Directive for Healthcare or Durable Power of Attorney or Living Will?

☐ Yes
☐ No

Has Harmony received a copy of Client's Advance Directive prior to this visit?

☐ Yes
☐ No

If Harmony has not received a copy of Client's Advance Directive, I understand it is my responsibility to present a current copy on each visit.

THE UNDERSIGNED CERTIFIES THAT I HAVE READ THE ABOVE PROVISIONS OF THIS AGREEMENT, RECEIVED A COPY OF THIS AGREEMENT, AND I AM THE CLIENT'S/PATIENT'S LEGAL REPRESENTATIVE, DULY AUTHORIZED TO EXECUTE THE ABOVE AGREEMENT AND TO ACCEPT ITS TERMS.

Dated : ______________________________

Time : ______________________________

Patient Name : ______________________________

SSN : ______________________________

Signature of Parent or Guardian : ______________________________

In the presence of:

Witness Signature : ______________________________

Financial responsibility agreement by person other than the Client, or the Client's legal representative:

I agree to accept financial responsibility for services rendered to the Client and to accept the terms of the financial agreement, assignment of insurance benefits, and health care service plan obligation provisions (SECTIONS ONE, TWO, and THREE, respectively) of the above agreement.

Responsible Party/Guarantor : ______________________________

SSN : ______________________________

Signature : ______________________________

In the presence of : ______________________________
Print Name

Witness Signature : ______________________________

Office Policies - Effective March 16, 2020

New Client Appointments: There is a $100 fee charged for missed appointments or cancellations that occur less than 24 hours (or 1 business day) prior to the set appointment time.*

This fee must be paid, or an acceptable payment arrangement must be made prior to scheduling another appointment. The payment arrangement will be determined on a client to client basis. Failure or Refusal to pay will result in termination of care.

Established Client Appointments: There is a $50 fee charged for missed appointments or cancellations less than 24 hours (or 1 business day) prior to set appointment time.

** Please note: No-Show fee for neuropsychological testing is different from these appointments, please refer to **NEUROPSYCHOLOGICAL TESTING** missed appointment charges below.*

This must be paid, or an acceptable payment arrangement must be made prior to scheduling another appointment. The payment arrangement will be determined on a client to client basis. Failure or Refusal to pay will result in termination of care.

Please know that we value our relationship with the Client, and we have set aside a specific appointment just for Client. While we understand that situations occur which may prohibit Client from making it to Client's scheduled appointment, please know that there is still a cost incurred by our practice even when Client doesn't come. There is a loss of time for the provider Client was to see, along with the continuation of maintaining staff and building maintenance/utilities. For this reason, we have a missed/cancellation fee in place as part of our office policy directives.

No Walk-In-Visits: If Client has missed or failed to schedule a return visit Client will not be seen as a Walk-In patient. Due to the high volume of patients, as well as the inconvenience this may cause clients that are already scheduled, we are unable to accommodate clients that just walk in the office. Therefore, we request that you schedule an appointment with the provider Client would like to see.

In case of an emergency please CALL 911 or go to the nearest emergency room available to you.

Prescription Refills: Prescription refills or requests must have a follow up appointment. You are responsible to keep track of Client's medications and request refills during Client's scheduled appointment with the provider.

Controlled Medications: (Narcotics/Benzodiazepines/Stimulants/Hypnotics): If Client is prescribed a controlled substance and you misplace the written prescription and/or the medication itself, you will not be given another prescription until Client is due. It is the Client's or Parent's or Guardian's responsibility to keep medications in a safe place. If Client take more than is prescribed, and you do not discuss this matter with the physician/ARNP/PA, you will not be granted an early refill without an appointment. If it is found that your prescribed medication is being abused this could result in immediate termination of care. The state of Florida follows all controlled substance medications in a secure website called E-FORCSE. Harmony United Psychiatric Care does check on

clients to see what controlled substances are prescribed. If it is found that Client is being prescribed the same controlled medication from another provider this will be cause for termination of care.

Paperwork: Forms for Disability, FMLA and other paperwork that need to be completed by our office will have a fee of $50 to $250 depending on the complexity and time required to complete the paperwork. These services are not covered by insurance. Therefore, Florida Statutes permits imposing a fee for these types of services to be fulfilled. This fee must be paid by the client prior to completion of the paperwork.

Insurance: It is the Client's responsibility to know Client's insurance coverage. All services rendered that are not covered by the insurance will be Client's responsibility for payment in full.

Balance/Payment: Payment is due at the time of service. It is the client's responsibility to keep their account in good standing. If there is a balance, this should be paid in full or an acceptable payment plan must be made with the billing office. The payment plan will be approved on a client by client basis. Failure to keep the Client's account in good standing can result in termination of care.

The billing office number is 352-504-0652.

Returned Checks: Returned checks will result in a fee of $35, plus the current balance due amount. This must be paid prior to any future appointments being scheduled or an approved payment arrangement must be made with the Billing Department. The payment arrangement will be decided on a client to client basis. Harmony United has the right to refuse future checks from those clients.

Medical Records: Medical Records will be released with a completed HIPAA (Health Insurance Portability and Accountability Act) compliant medical record release form. There will be a fee charged for paper or electronic copies of medical records provided directly to the patient or to governmental or non-governmental entities. Fees will be charged as below:

- Records requested by someone other than the patient (Non-Governmental): Paper records will be charged $1.00 per page; Sales Tax and Actual Postage will be charged additionally
- Records Requested by the patient or governmental entities: Records will be charged $1.00 per page for the first 25 pages. For each page in excess of 25 pages there will be charged $0.25 per page. The cost of reproducing non-written records such as X-Rays will be charged at the actual cost to make the reproduction.
- There is no charge for medical records that are being sent to a healthcare provider when arranging transition of care or related to communications between healthcare providers.

Phone Visits or Provider Call Back Services:

Telephone communication with our office staff regarding any aspect of Client's care (insurance, billing, medication refills, questions related to side effects of medications, prior authorization requests, medical records, any other paperwork request, etc.) is free of charge. Although, in most cases where our office staff needs to communicate with Client's healthcare provider in our practice to get answers to your questions we typically do not charge for these services.

However, if Client is an established client of our practice and you (or Client's family members) would like to request to speak with the provider over the phone directly to discuss Client's mental health condition, discuss Client's medications, to seek medical advice, or discussion about any aspect of Client's care, then these phone services are billable provider time.

For Clients with Insurance: Phone services will be billed to the insurance carrier. Please be aware that if Client has any co-pay, coinsurance or deductible with the insurance plan then it will be applicable to these phone visits in a similar fashion as they would to Client's regular office visit.

For Self -Pay Clients: There will be a charge for every returned call by provider, billed at a rate of $25 (twenty-five) for 5 mins. The calls will be billed in 5-minute increments.

Clients without insurance coverage must pay a "self-pay" fee at the time of service. Also, a $100 deposit will be collected before Client's first visit is scheduled, that can be refunded at the end of the treatments if the balance is paid.

The fee schedule for self-pay clients is as follows:

Medication Management:

• New Client - initial psychiatric evaluation for medication management - $300

• Established Client- Follow Up Appointments - $150 per visit.

Psychotherapy/Counseling: Including: Individual and Couples/Marriage Counseling

• New Client- Initial psychiatric evaluation for psychotherapy/counseling is $200.

• Established Client- Follow Up Psychotherapy Appointments is $150 per session.

• For Marriage/Couples counseling - the first visit with the therapist must be individual sessions for each client and then follow up visits will include both clients seeing the therapist as a couple during the same session.

NEUROPSYCHOLOGICAL TESTING:
Testing for ADHD/Dementia/TBI/Autism Spectrum Disorder, etc.

The Evaluation will be conducted in two to three parts. The Initial Appointment will take up to three (3) hours. The follow-up appointment will be for two (2) hours for test interpretation and any additional follow-up visit will be scheduled if recommended by the Provider.

Missed Appointment Policy: There is a $150 fee charged for any New or Follow-Up testing missed appointment or cancellations that occur less than 48 hours (or 2 business days) prior to the set appointment time. The Missed Appointment fee must be paid, or an acceptable payment arrangement must be made prior to scheduling another appointment. The payment arrangement will be determined on a client by client basis. Failure or refusal to pay the fee will result in termination of care.

Insured Patients

• An Advance Deposit of $200 is required before scheduling your testing appointment, from which $50 will be used to cover the cost of testing materials.

• Any Missed Appointment fees incurred by Client will be deducted from the Advanced Deposit.

• Any remaining balance of the Advance Deposit will be refunded to the Client upon completion of the testing.

Neurocognitive Testing

• The Initial Neurocognitive Test is scheduled in the Clinic office or the test can be sent to the Client to complete On-line. The charge is $150.00 for one hour (in Clinic testing) and the cost is the same for on-line testing. The cost of testing is not covered by insurance.

The testing result interpretation will be part of the Client's next scheduled follow-up visit, which is billed to their insurance.

Self-Pay Patients

• The Testing Fee for the Evaluation is $900, which includes up to 6 hours of time for the evaluation, generating the report, and cost of testing materials. However, if additional time is required then it will be billed at $150 per additional hour.

• An Advance Deposit of $300 is required before scheduling the testing appointment. Testing Fees will be applied to the Advance Deposit.

• Any Missed Appointment fees incurred will be deducted from the Advanced Deposit.

HIPAA Privacy Policy

Protecting the privacy and the confidentiality of the Client's/Patient's personal information is important to the physicians and staff at Harmony United Psychiatric Care. We strive to provide our clients and patients with excellent care and service. Every member of our staff must abide by our commitment to privacy in the handling of personal information. Our Privacy Policy applies to the personal health information of all patients that is in our possession and control.

What is Personal Health Information or PHI? Personal Health Information means information that identifies an individual relating to his or her physical or health (including medical history), the providing of mental health care to the individual, and payments or eligibility for health care.

Accountability: We take our commitment to securing patient privacy very seriously. Each healthcare provider and employee associated with the practice is responsible for the personal information under his or her control. Our employees are informed about the importance of privacy.

Identifying purposes: We ask and collect information to establish a relationship to serve your Client's mental health needs. We obtain most of your information about your Client directly from you or from your referring physician whom you have authorized to disclose information. We limit the information we collect to what we need for the purposes of our practice to treat your Client's mental health needs. We will obtain your consent if we wish to use this information for other purposes.

You have the right to determine how your Client's personal health information is used and disclosed. For most healthcare purposes, your consent is implied as a result of your consent to treatment. However, in all circumstances express consent must be written. Your written consent will be forwarded to the Privacy Officer who will document the request in the Client's medical records and notify the appropriate health care providers and their supporting staff.

Personal Health Information permits certain collections, uses, and disclosures of your Client's PHI, despite the consent directive; healthcare providers may override the consent directive in certain circumstances such as emergencies and the consent directive may result in delays in receiving health care.

A. Permitted Disclosures of PHI. We may disclose Client's PHI for the following reasons:

1. Treatment. We may disclose Client's PHI to a physician or other health care provider providing treatment to Client. For example, we may disclose medical/mental health information about Client to physicians, nurses, technicians or personnel who are involved with the administration of Client's care.
2. Payment. We may disclose Client's PHI to bill and collect payment for the services we provide to Client. For example, we may send a bill to you or to a third-party payer for the rendering of services by us. The bill may contain information that identifies Client's diagnosis and procedures and supplies used. We may need to disclose this information to insurance companies to establish insurance eligibility benefits for the Client. We may also provide Client's PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims.

3. Health Care Operations. We may disclose Client's PHI in connection with our health care operations. Health care operations include quality assessment activities, reviewing the competence or qualifications of health care professionals, evaluating provider performance, and other business operations. For example, we may use PHI to evaluate the performance of the health care services Client received. We may also provide PHI to accountants, attorneys, consultants and others to make sure we comply with the laws that govern us.
4. Emergency Treatment. We may disclose PHI if you require emergency treatment or are unable to communicate with us.
5. Family and Friends. We may disclose PHI to a family member, friend or any other person whom you identify as being involved with Client's care or payment for care, unless you object.
6. Required by Law. We may disclose PHI for law enforcement purposes and as required by state or federal law. For example, the law may require us to report instances of abuse, neglect or domestic violence; to report certain injuries such as gunshot wounds; or to disclose PHI to assist law enforcement in locating a suspect, fugitive, material witness or missing person. We will inform you as Client's representative if we disclose PHI because we believe Client is a victim of abuse, neglect or domestic violence, unless we determine that informing you would place you or Client at risk. In addition, we must provide PHI to comply with an order in a legal or administrative proceeding. Finally, we may be required to provide PHI in response to a subpoena discovery request or other lawful process, but only if efforts have been made, by us or the requesting party, to contact you about the request or to obtain an order to protect the requested PHI.
7. Serious Threat to Health or Safety. We may disclose your PHI if we believe it is necessary to avoid a serious threat to the health and safety of you or the public.
8. Public Health. We may disclose PHI to public health or other authorities charged with preventing or controlling disease, injury or disability, or charged with collecting public health data.
9. Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These activities include audits; civil, administrative or criminal investigations or proceedings; inspections; licensure or disciplinary actions; or other activities necessary for oversight of the health care system, government programs and compliance with civil rights laws.
10. Research. We may disclose PHI for certain research purposes, but only if we have protections and protocols in place to ensure the privacy of PHI.
11. Workers' Compensation. We may disclose PHI to comply with laws relating to workers' compensation or other similar programs.
12. Specialized Government Activities. If Client is active military or a veteran, we may disclose Client's PHI as required by military command authorities. We may also be required to disclose PHI to authorized federal officials for the conduct of intelligence or other national security activities.
13. Organ Donation. If Client is an organ donor or you have not indicated that you do not wish Client to be a donor, we may disclose PHI to organ procurement organizations to facilitate organ, eye or tissue donation and transplantation.

14. Coroners, Medical Examiners, Funeral Directors. We may disclose PHI to coroners or medical examiners for the purposes of identifying a deceased person or determining the cause of death, and to funeral directors as necessary to carry out their duties.
15. Disaster Relief. Unless you object, we may disclose Client's PHI to a governmental agency or private entity (such as FEMA or Red Cross) assisting with disaster relief efforts.

B. Disclosures Requiring Written Authorization.

1. Not Otherwise Permitted. In any other situation not described in Section A above, we may not disclose Client's PHI without your written authorization.
2. Psychotherapy Notes. We must receive your written authorization to disclose psychotherapy notes, except for certain treatment, payment or health care operations activities.
3. Marketing and Sale of PHI. We must receive your written authorization for any disclosure of PHI for marketing purposes or for any disclosure which is a sale of PHI.

C. Client's Rights.

1. Right to Receive a Paper Copy of This Notice. You have the right to receive a paper copy of this Notice upon request.
2. Right to Access PHI. You have the right to inspect and copy Client's PHI for as long as we maintain Client's medical record. You must make a written request for access to the Privacy Officer at the address listed at the end of this Notice. We may charge you a reasonable fee for the processing of your request and the copying of Client's medical record pursuant to Chapter 456, Florida Statutes. In certain circumstances we may deny your request to access Client's PHI, and you may request that we reconsider our denial. Depending on the reason for the denial, another licensed health care professional chosen by us may review your request and the denial.
3. Right to Request Restrictions. You have the right to request a restriction on the use or disclosure of Client's PHI for the purpose of treatment, payment or health care operations, except in the case of an emergency. You also have the right to request a restriction on the information we disclose to a family member or friend who is involved with Client's care or the payment of Client's care. However, we are not legally required to agree to such a restriction.
4. Right to Restrict Disclosure for Services Paid by You in Full. You have the right to restrict the disclosure of Client's PHI to a health plan if the PHI pertains to health care services for which you paid in full directly to us.
5. Right to Request Amendment. You have the right to request that we amend Client's PHI if you believe it is incorrect or incomplete, for as long as we maintain your medical record. We may deny your request to amend if (a) we did not create the PHI, (b) is not information that we maintain, (c) is not information that you are permitted to inspect or copy (such as psychotherapy notes), or (d) we determine that the PHI is accurate and complete.

6. Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures of PHI made by us (other than those made for treatment, payment or health care operations purposes) during the 6 (six) years prior to the date of your request. You must make a written request for an accounting specifying the time period for the accounting, to the Privacy Officer at the address listed at the end of this Notice.
7. Right to Confidential Communications. You have the right to request that we communicate with you about Client's PHI by certain means or at certain locations. For example, you may specify that we call you only at your home phone number, and not at your work number. You must make a written request, specifying how and where we may contact you, to the Privacy Officer at the address listed at the end of this Notice.
8. Right to Notice of Breach. You have the right to be notified if we or one of our business associates become aware of a breach of Client's unsecured PHI.

D. Changes to this Notice.

We reserve the right to change this Notice at any time in accordance with applicable law. Prior to a substantial change to this Notice related to the uses or disclosures of Client's PHI, your rights or our duties, we will revise and distribute this Notice.

E. Acknowledgment of Receipt of Notice.

We will ask you to sign an acknowledgment that you received this Notice.

F. Questions and Complaints.

If you would like more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated Client's privacy rights, or you disagree with a decision we made regarding the use, disclosure, or access to Client's PHI, you may submit a complaint to us by contacting the Privacy Officer at the address and phone number at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We can provide you with the address to file such a complaint upon request.

Limiting Collection: We collect information by fair and lawful means and collect only that information which may be necessary for the purposes related to the provision of your medical care. Under no circumstances do we sell patient lists or other personal information to third parties. There are some types of disclosure of Client's PHI that may occur as a part of this practice fulfilling its routing obligations and practice management. This includes consultants and suppliers to the practice, on the understanding that they abide by our privacy policy, and only to the extent necessary to allow them to provide business services or support this practice.

We will retain Client's information only for the time it is required for the purposes we determine, and once Client's personal information is no longer required, it will be destroyed. However due to our ongoing exposure to potential claims, some information is kept for a longer period of time.

Safeguards: We protect Client's information with appropriate safeguards and security measures. The practice maintains personal information in a combination of paper and electronic files. Recent paper records concerning individual's personal information are secured and kept on site at our office.

Access to personal information will be authorized only for the healthcare providers and employees associated with the practice and other agents who require access in the performance of their duties, and otherwise authorized by law. We provide information to health care providers acting on Client's behalf, understanding that they are also bound by law and ethics to safeguard Client's privacy.

Our computer systems and electronic medical records are password secured and constructed in such a way that only authorized individuals can access secure systems and databases. All our employees use HIPAA compliant email which is encrypted. However, sending emails to the office via email server that is not HIPAA Compliant is not secure against interception. Our practice does not encourage email communication of sensitive information if you do not use encrypted or HIPAA compliant email service. We request that you call the office with any requests, problems, or information. If you have any additional questions or concerns about privacy, we invite you to contact us by phone and we will address your concerns to the best of our ability.

Access to correction with limited exceptions: We will give you access to the information we retain about Client within a reasonable time, upon presentation of a written request and satisfactory identification. We may charge you a fee for this service and if so, we will give you notice in advance of processing your request. If you find errors of fact in your personal health information, please notify us as soon as possible and we will make the appropriate corrections. We are not required to correct the information relating to clinical observations or opinions made in good faith. You have a right to append a short statement of disagreement to Client's record if we refuse to make a requested change. If we deny your request for access to Client's personal information, we will advise you in writing of the reason for the refusal and then you may challenge our decision.

We encourage you to contact us with any questions or concerns you might have about Client's privacy. We will investigate and respond to your concerns about any aspect of handling Client's information.

HIPAA Privacy Policy

Harmony United Psychiatric Care
301 Skyline Drive Suite 4
Lady Lake, FL 32159

Release of Medical Records / Client Information

I, ______________________________________ am Parent or Guardian for ______________________________________

"Client" whose Date of Birth is: ___________________ and I hereby authorize Harmony United Psychiatric Care to:

Release _____ OR Obtain _____ the following information pertaining to Client:

- __ Ongoing comprehensive treatment coordination.
  (including history and physical, progress notes, all labs/Imaging, etc.)
- __ Presence in treatment, including admission and discharge dates.
- __ Diagnosis, brief progress notes and prognosis.
- __ Psychological Assessment, Psychotherapy Notes.
- __ Psychiatric evaluations and management.
- __ Substance Abuse evaluation and treatment.
- __ Other: ____

This information may be: Released to _____ Obtained from _____ Physician/Company/ Hospital/ Person

Name : ____

Address : ____

Phone : ____

Fax : ____

This information is being requested for the following:

- __ To coordinate with other healthcare providers.
- __ To provide on-going treatment.
- __ To enable judges, attorneys, probation/parole officers to support treatment goals
  and/or to make informed legal decisions
- __ To coordinate treatment efforts with my family/concerned persons.
- __ To coordinate treatment and continuing care efforts with my employer.
- __ To obtain insurance, employment or government benefits.
- __ For emergency purposes, ONLY.
- __ Other ____

Release of Medical Records / Client Information *Continued*

If submitting patient records via mail to Harmony United Psychiatric Care, please send to:

301 Skyline Drive Suite 4
Lady Lake, FL 32159

If submitting electronically, send to:
FAX: (352) 431-3173 or EMAIL: info@hupcfl.com

NOTE: When substance abuse or dependence issues are relevant in Client's medical records, I understand that the Release of Medical Records/Client Information has been disclosed from records whose confidentiality is protected by Federal Law.

Federal regulations (42CFR part 2) prohibit any further disclosure without specific written consent of the person it concerns. A general authorization for the release of medical or other information is not enough for this purpose.

This authorization shall remain in effect until:

___ Further notice of closing of case

___ Specific: Start date: ______________ to Expiration date: ______________

___ Specific Event____

I do voluntarily for the purpose(s) specified above, have the right to revoke this authorization, in writing, at any time. However, this revocation will not be effective to the extent that action has already been taken in compliance of my consent or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used, disclosed, or obtained pursuant to the authorization may be subjected to re-disclosure by the recipient to Client's information and no longer protected by the HIPAA privacy rule.

By signing this form, I authorize the use and disclosure of Client's health information in the manner described on the **"Release of Medical Records/ Client Information"** page. I have signed this form voluntarily in order to document my wishes for Client regarding the use and disclosure of Client's health records.

➡ ________________________________ ________________________________
Signature of Parent / Guardian **Date**

➡ ________________________________
Print Name

➡ ________________________________ ________________________________
Signature of Witness **Date**

➡ ________________________________
Print Name