OFFICE USE ONLY
BDI INFO:_____
DX:

PLEASE BE SURE TO BRING THESE COMPLETED FORMS TO YOUR FIRST SESSION SO WE DON'T HAVE TO USE ANY OF YOUR SESSION TIME FOR PAPERWORK.

Chris Kalamon. LCSW
777 S. Wadsworth Blvd.
Bldg 1, Suite 203
Lakewood, CO 80226

303-257-7991 phone
720-962-4800 fax

DATE_____

PATIENT INFORMATION Print Clearly. (For couple's, both parties must individually complete this section and the next section on physical and mental health):

Name_____ **Age**_____ **Birth date**_____

Street _____ **City**_____**Zip**_____

Education_____ **How did you find us?** _____

Employer_____ **Job Title** _____

_____
EMAIL ADDRESS (required) Print clearly. (Used for scheduling. Do not send personal information via email)

At times, I may need to contact you.

Home Phone Number: _____ OK to call? Y N

Work Phone Number: _____ OK to call? Y N

Cell Phone Number: _____ OK to call? Y N

Best way to contact you: home work cell all numbers

Status: (circle one) S M D W LGBTQ Other_____

Who currently lives with you? _____

Primary issue you'd like to work on / goals for therapy_____

_____

LOCAL (COLORADO) EMERGENCY CONTACT – This section must be completed with a contact name who lives in COLORADO.

I may take some action, such as seek an order for your emergency or involuntary commitment, if I deem you to be a serious harm to yourself or others. We may or may not be able to discuss this ahead of time. I may also decide it is necessary to contact a friend or relative if I become alarmed about your safety. By providing this information, you are giving me permission to use it if I feel an emergency has developed. **Please tell your emergency contact that they may receive a call from me and to put me on their "favorites" phone list so I can reach them at any time in case of an emergency**. Thank you.

Name_____Phone#_____Relationship_____

Medical & Psychological History (Parents, Guardians - please assist patient as necessary)

Date of last physical:_____

Have you ever been in therapy before? Yes No If yes, when and for how long?_____

_____

Have you ever been hospitalized for psychiatric care? Yes No If yes, please list dates & reasons:

_____

Is there a history of mental illness in your family of origin? Yes No If yes, please list who and what illness/es :

_____

_____

List all <u>current</u> medications (for medical and psychological issues):

Medication Name	Dosage	Diagnosis	Symptoms	How Long Diagnosed?

Have you experienced any of the following in the past two years? (Check all that apply)

- ❑ Frequent colds/flu
- ❑ Backaches
- ❑ Problems with vision
- ❑ Dizziness
- ❑ Headaches
- ❑ Change in eating habits
- ❑ Weight loss/gain
- ❑ Irritability
- ❑ Fatigue
- ❑ Sleep problems
- ❑ Memory/concentration problems
- ❑ Thoughts about suicide
- ❑ Attempts of suicide-when? _____
- ❑ Depression
- ❑ Anxiety/nervousness
- ❑ Stomach problems
- ❑ Intrusive thoughts/sounds
- ❑ Pre-menstrual problems
- ❑ High blood pressure
- ❑ Excessive stress
- ❑ Problems with hearing
- ❑ Sexual problems
- ❑ Difficulty breathing
- ❑ Problems concentrating
- ❑ Thoughts of hurting others
- ❑ Violence against others
- ❑ Chest pain
- ❑ Other

Have any of the following events occurred in your life in the past two years? (Check all that apply)

- ❑ Death of friend or family member
- ❑ Change in close personal relationship (divorce, separation, etc.)
- ❑ Serious problems with friend/family
- ❑ Personal injury, illness, accident
- ❑ Family injury, illness, accident
- ❑ Major change in job status
- ❑ Serious job-related difficulties
- ❑ Accused of crime
- ❑ Victim of crime
- ❑ Major geographic relocation
- ❑ Sexual/physical abuse or rape
- ❑ Sexual harassment
- ❑ Marriage
- ❑ Birth of child
- ❑ Abortion
- ❑ Miscarriage
- ❑ Surgery
- ❑ Legal problems
- ❑ Financial problems
- ❑ Gambling problems
- ❑ Other _____

FINANCIAL POLICY

Chris Kalamon, 777 S. Wadsworth Blvd, Suite 1-203, Lakewood, CO 80226. 303-257-7991

RATES. We do not accept insurance for **Couples Therapy and EMDR** sessions.

- *Individual Therapy*: 1st Session - $190. Other sessions - $142. Insurance may cover. Longer sessions available.
- *Couples Therapy:* 1st Session, $250. Future sessions - $190. Insurance not accepted.
- *EMDR Therapy*: All Sessions, **$**170**.** Insurance not accepted.
- *EAP / Victims Comp:* Please discuss with therapist.

INSURANCE. **It is *your responsibility* to know your plan.** Insurance payments depend upon eligibility and coverage once our office submits a claim. In the event that your insurance company denies payment for any reason, we bill you for the full cost of therapy.

BILLING SERVICES. I contract with **Medical Billing Services Corp (MBS).** They will verify to the best of their ability your insurance benefits. At times they may contact you to review your insurance account. The account manager is Regina at 303-487-4965. Upon your request, she can provide a statement of services. Outstanding amounts are charged to your credit card and / or sent to collections.

OVERDUE ACCOUNTS. You will be charged a rebilling fee of $5.00 per month (subject to change) from the date of initial billing for any balance over 30 days on your account. Accounts 45 days or older are **AUTOMATICALLY** charged to your credit card account. Delinquent accounts (including confidential information) may be turned over to a national collection service. Applicable late fees are your responsibility. These include, but are not limited to, interest fees, agency fees, attorney fees and court costs.

ADDITIONAL COSTS. **Insurance does not cover these costs**. **Returned checks** are charged a fee of $30.

All Court Proceedings / Custody / Divorce. Please do not use our services if you believe you will be involved in litigation. My role as a therapist is not to make recommendations for the court concerning custody or parenting issues. We will NOT testify in court concerning opinions on issues involved in any litigation, and we ask you to accept our policy. If you go to court, you will have to ask another professional to testify. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. *Because of the difficulty of legal involvement*, *I charge $400 per hour for preparation and attendance, port-to-port, at any legal proceeding.* **A $1500 deposit is required prior to any work**.

Phone Calls. I may be required to consult with you, your PCP, psychiatrist, insurance company and/or other professionals. Many times your insurance company requests this. We bill on a pro-rated basis ($190 per hour) for consultations involved in coordinating your care.

Insurance Reports / Records. Files are not released from this office. Instead, a written summary is provided (starting at a minimum charge of $190). This includes, but is not limited to, requests from attorneys, psychiatrists, doctors, insurance companies, as well as paperwork for FMLA, disability status, life insurance, etc. **Advance payment is required**. See Private Practice Policy for information on records.

LATE CANCELS / NO SHOWS. Our current full fee of $142 or more (NOT your copay) will automatically be charged to your credit card for all missed appointments or those cancelled without 24-hours advance notice. Insurance does not cover this. These terms are subject to change.

PRE-AUTHORIZED / GUARANTEED CREDIT CARD PAYMENT – REQUIRED **Please read and sign the following:** I authorize *Medical Billing Services and the office of Chris Kalamon* to AUTOMATICALLY charge my credit card account for balances of charges due from me that are 45 days or older. My credit card will also be AUTOMATICALLY charged for late cancels / missed appointments / service fees not covered by insurance. Upon request, a receipt of the charges will be provided. There may be a 3.5% administrative fee applied to credit card charges.

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ _____ _____

Credit Card Number PRINT CLEARLY | Expiration Date | C V V code (3 digit # on back of card)

_____ _____ _____

ZIP CODE (affiliated with credit card) | FULL NAME ON CARD (Print) | Cardholder Signature

I have read the preceding information and I understand that I am responsible for the payment of all professional services rendered. A party responsible for financial fees must sign for patients younger than 18.

_____ _____

Print Patient Name(s) | Date

_____

Patient Signature or Responsible Party & relationship

We reserve the right to change our financial policy and our rates at any time.

2/22/2021

Professional Disclosure Statement

Chris Kalamon, 777 S. Wadsworth Blvd, Suite 1-203, Lakewood, CO 80226. 303-257-7991

1. Masters of Social Work, University of Denver (accredited Council on Social Work Education (CSWE) Program)
   Bachelor of Science, Communications & Marketing, S.I. Newhouse School of Communications (dual degree program)
   Bachelor of Arts, French Literature and Language, Syracuse University (dual degree program)

2. Licensed Clinical Social Worker – LCSW #992835. Requirements: jurisprudence exam, clinical exam by the Association of Social Work Boards (ASWB), 3360 clock hours of post-graduate work experience over 24 months, 96 clock hours of post-degree supervision over 24 months with a Licensed Clinical Social Worker. Forty professional development hours every 24 month period for continuing education and license renewal.

3. Member: National Association of Social Workers (NASW), Team Coordinator of Response Works, Boulder Psychotherapy Institute, Colorado Therapists in Private Practice, Denver Therapist Connection, Online Therapy Professionals, Peer Support Groups, Supervision to Therapists Seeking Licensure,

4. The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Social Work Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7760. As to the regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a masters degree in their profession and have two years of post-masters supervision and two years of post-masters work experience. I am a Licensed Clinical Social Worker. As to the regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a masters degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a masters degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

5. Any person who alleges that a mental professional has violated the licensing laws related to the maintenance of records of a client eighteen years of age or older, must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably should have discovered this. Pursuant to law, this practice will maintain records for a period of seven years commencing on the date of termination of services or on the date of last contact with the client, whichever is later.

6. Patient Rights and Important Information: You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy, if known, and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.

7. In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

8. All parties in the office suite located at 777 S. Wadsworth Blvd., Building 1, Suite 203, Lakewood CO, 80226, are separate business entities and occupy this space for office use purposes only.

9. As a psychotherapist, I may consult with a variety of experts on treatment issues in a manner which protects confidentiality.

10. The information provided by and to the patient during therapy sessions is legally confidential and cannot be released without the patient's consent. There are exceptions to this confidentiality, some of which are listed in Section 12-43-218 of the Colorado Statutes and the Notice of Privacy Rights you reviewed and signed here as well as in Colorado and Federal law. Some of the circumstances where disclosure is required by the law are: reporting suspected child, dependent, or elder, abuse or neglect; and where a patient presents a danger to self or others.

    There are certain legal exceptions where disclosure may be required pursuant to a legal proceeding. If feasible, these will be identified within therapy should the situation arise. See the Private Practice Policy sheet for further information and details about confidentiality and records.

Surprise Billing – Know Your Rights. Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or
- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado

What is surprise/balance billing, and when does it happen? If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network

health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called “surprise” or “balance” billing.

When you CANNOT be balance-billed:

Emergency Services If you are receiving emergency services, the most you can be billed for is your plan’s in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care.

Nonemergency Services at an In-Network or Out-of-Network Health Care Provider. The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for covered services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.
- No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency other situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed.

If you want to file a complaint, you can submit an online complaint here: https://www.colorado.gov/pacific/dora/DPO_File_Complaint.

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the billing department, or the Colorado Division of Insurance at 303-894-7490 or 1-800-930-3745.

*This law does NOT apply to ALL Colorado health plans. It only applies if you have a “CO-DOI” on your health insurance ID card. Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.

I have read this information and I understand my rights as a patient or as the patient’s responsible party.

Patient’s Name _____ Date_____

Patient’s Signature or Responsible Party’s Signature _____

_____
If signed by Responsible Party, please state relationship to patient and authority to consent

PRIVATE PRACTICE POLICIES

Chris Kalamon, 777 S. Wadsworth Blvd, Suite 1-203, Lakewood, CO 80226. 303-257-7991

Welcome! I am available to discuss any of your assumptions, problems or possible side effects in our work together. Psychological services are best provided in an atmosphere of trust. You expect me to be honest with you about your progress. I expect you to be honest with me about your expectations for service, your compliance with our fee agreement and appointment policy, and any other barriers to treatment.

APPOINTMENT POLICY. Weekly sessions will benefit you the most. Cancelling without rescheduling for the same week disrupts the therapeutic process and extends your therapy. We do enforce our cancellation policy in most situations. If a session is not cancelled before the 24-hour period, it is difficult to offer it to someone who is waiting.

- **Repeated Cancellations or Missed Appointments** will be discussed as it may be a sign of a larger issue.
- Our full fee (of $142 or more)) will automatically be charged to your credit card for missed appointments or those cancelled without 24-hours advance notice. An administrative fee is applied to all credit card charges. These terms are subject to change.

CONFIDENTIALITY. The information you discuss during a session is protected as confidential under law (CRS 12,43,214 (l)(d)) with certain limitations:

- It is the law that I report **suspected** child, dependent, or elder abuse (physical, emotional, and/or sexual) or neglect, to the proper authorities who may then investigate. An investigation by me is NOT required in order to report abuse.
- If you file an official complaint or a lawsuit against me, according to Colorado law, your right to confidentiality will be waived.
- Clerical persons hired by me may have access to limited confidential information. This information is protected from further disclosure and is used solely for administrative purposes.
- If you use your insurance I cannot protect who else will see it once I release the information. In addition, your insurance company may request a summary report. I am required to provide it. Failure to do so may mean a denial of benefits and/or payment of claims. Fees are applied to these requests (see financial policy). I cannot protect how information is used and who has access to it.
- When I am away from my office, I may ask another licensed therapist to cover emergencies for me. Generally, I will tell this therapist only what he or she needs to know for an emergency.

RECORDS. Include identifying information, dates and types of sessions, an assessment and diagnosis, a treatment plan, progress notes, and any consultations made. Your records will be stored safely with attention to your privacy for at least seven years as required by Colorado Statute.

- At times, your records are requested by your insurance company for disability status, life insurance, or other reasons. I do not release an entire record, even with your consent. Instead, I provide a written summary of the content related to the request. You are billed for this summary as outlined in the REPORTS section of our Financial Policy**.** We will review the summary before it is released.
- For couple or family sessions, all adults present over the age of 15 will have to sign the release. You will be granted reasonable access to your record. You may request, in writing, an amendment to your record. If you choose to read your record, it is my policy to be present in order to respond to any questions or confusion you may have about the recordings. This is considered billable time.
- Private psychotherapy notes are kept separate and are further protected from unauthorized access. Psychotherapy notes are not made available for review. These notes will be used only by your therapist and disclosure will occur only under these circumstances: (a) the therapist who wrote the notes uses them for your treatment; (b) they may be used for training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills; (c) if you bring a legal action and we have to defend ourselves; and (d) certain limited circumstances defined by the law.

AVAILABILITY. Hours for regular phone calls are 9 a.m. to 5 p.m. Mon – Fri. I will attempt to return your call within one business day. For immediate assistance or life-threatening situations, please call 911 or go to your nearest emergency room.

TERMINATION. Termination will usually be agreed upon mutually. In some situations, I may decide to stop working with you even though you wish to continue. These include a failure to meet the terms of our fee agreement, continued failure to comply with our appointment policy, a need for special services outside of the area of my competency, and delayed progress in our work together. Should this occur, the reason for termination will be discussed with you.

I have read the preceding information and understand my rights and responsibilities as a patient. I accept, understand and agree to abide by the contents and terms of this agreement and further consent to participate in evaluation and/or treatment.

Patient Name_____**Signature**_____

Date _____

Chris Kalamon. LCSW
777 S. Wadsworth Blvd.
Suite 1 - 203
Lakewood, CO 80226

303-257-7991 phone
720-962-4800 fax

Complete this form only if you are using your insurance.

OFFICE USE ONLY Initial DX:_____ Date of 1st Session_____

Contact my insurance manager Regina at 303-487-4965 prior to your 1st visit.
You will be charged our FULL fee if your insurance account is not set up and your benefits have not been verified by our office.

INSURANCE INFORMATION

All Questions Must Be Answered - (please bring your insurance card so that we may make a copy)

Patient Name (please print) | **Patient Date of Birth** | **Patient Insurance ID / Policy Number** | **Relationship to Policy Holder**

Your Address (required): _____
Street **City** **State** **Zip**

Your phone number | **Employer** | **Position**

Policy Holder - All information below is in reference to the policy holder and must be provided:

Name | **Birth Date** | **Policy Holder Insurance ID / Policy Number**

Name of Insurance Plan | **Insurance Group Number** | **Insurance Phone Number (back of card)**

Call your insurance company for the following information.

# of sessions for the year | **Plan renewal date** | **Co Pay** | **Authorization Code (required by some plans)**

Amount of deductible **Has deductible been met for this year? Yes No**

Please read our Financial Policy regarding insurance payments, denial of payment, and cancellations.

AUTHORIZATION TO RELEASE INFORMATION (required)

I authorize the release of any medical or other information necessary to (1) provide for adequate professional coverage in the absence of primary physician, (2) to verify insurance coverage and (3) to file and process a claim. I also authorize payment of medical benefits to the licensed psychotherapist for professional services rendered. I am responsible for any payments due that my insurance company does not pay.

Patient Signature_____ Date_____
Parent or guardian signature for patients under 18.

USING YOUR INSURANCE

Complete this form only if you are using your insurance.

I am committed to providing the best care possible and maintaining your confidentiality. That means protecting your records so that they cannot be seen by anyone who is not involved in your treatment.

However, when a third party enters into our contract, such as your insurance provider, I cannot control how they use your information. There are some things for you to know so that you can make an informed decision on whether or not to use your insurance coverage.

Insurance companies require all psychotherapists to provide certain information in order to approve your sessions. I am required to give you a mental health diagnosis. I must be honest and provide a diagnosis that will match up with your symptoms and information. This diagnosis may potentially affect you in the future. This includes, but is not limited to, disability coverage, life insurance, and your ability to obtain future employment, etc. Once I release it, I cannot protect how it is used and who has access to it. In addition, the diagnosis may or may not be covered under your plan. If it is not covered, you are required to pay the session fee.

Insurance companies hold the power to determine how many sessions you are entitled to. They may decide that you can only have a certain amount of sessions, whether or not treatment is complete. They may insist on a protocol (specific treatment plan) for your diagnosis. They may require medication. If you refuse to follow the protocol, you may be considered "noncompliant" and thereby denied benefits.

On a final note, if your insurance company requests your files and/or a summary report, either in writing or by phone, I am required to provide it. Failure to do so may mean a denial of benefits and/or payment of claims. Once released, I cannot protect how it is used and who has access to it.

I am moving away from accepting most insurance, but still accept Anthem Blue Cross PPO currently. I reserve the right to withdraw from participating with an insurance company at any time.

It is important for you to know that there may be some risks involved in using your insurance. I provide this information only so that you can be an informed consumer and make the decision that is best for you.

I have read the above. I understand Chris Kalamon cannot be held responsible for how my information is used once it is provided to my insurance company.

I would like to use my insurance benefits. (Circle one) Yes No

_____

Name Signature Date

Chris Kalamon, 777 S. Wadsworth Blvd, Suite 1-203, Lakewood, CO 80226. 303-257-7991

MEDICAID/MEDICARE

All patients must read and sign.

I am not a provider for MEDICARE or MEDICAID. Please read the information below and sign where indicated.

NOTIFICATION OF NON-ACCEPTANCE OF MEDICARE/MEDICAID

☐ I am NOT insured by Medicaid or Medicare.

I, _____, have been informed that Chris Kalamon is not a provider for Medicare and Medicaid. I understand that should I ever decide to seek coverage from Medicare/Medicaid, I must notify her immediately. At that time, we will discuss my options and decide whether or not I wish to continue to receive therapy from her. I understand that if I choose to stay with Chris Kalamon, I will have to pay out-of-pocket or seek payment from my secondary insurance company (if available and she is a provider for them).

I am aware that once I become insured by Medicare or Medicaid, I could seek treatment from a therapist (LCSW) who DOES accept assignment on Medicare/Medicaid patients at a lower cost to me.

_____

Signature Date

☐ I am insured by Medicaid or Medicare.

I, _____, do hereby acknowledge that I have been informed by Chris Kalamon, LCSW, that she does NOT accept assignment for Medicare or Medicaid patients.

As an individual insured by Medicare and/or Medicaid, I hereby voluntarily choose to seek and/or to continue treatment with Chris Kalamon, LCSW, by paying for such services out-of-pocket at her customary rates or by using my secondary insurance (if available and she is a provider for them). If Chris Kalamon is not a provider for my secondary insurance company, or some services are not covered by insurance benefits, I voluntarily choose to pay privately for those services.

I am aware that I could otherwise seek treatment from a therapist (LCSW) who DOES accept assignment on Medicare/Medicaid patients at a lower cost to me but I choose not to do so.

_____

Signature Date

NOTICE OF PRIVACY PRACTICES OF CHRIS KALAMON & ASSOCIATES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Effective April 14, 2003

If you have any questions about this Notice or would like a copy, please contact Chris Kalamon.

The Practice is required by State and Federal law to maintain the privacy of protected health information. In addition, the Practice is required by law to provide clients with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to your mental health information, and to request that you sign the written acknowledgement that you reviewed a copy of this Notice. This Notice describes how the Practice may use and disclose your protected health information. This Notice also describes your rights regarding your protected health information and how you may exercise your rights.

"Protected Health Information, PHI", is information the Practice has created or received about your physical or mental health condition, the health care we provide to you, or the payment for your health care; and identifies you or could be reasonably used to identify you. It includes your identity, diagnosis, dates of service, treatment plan, and progress in treatment.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Permissible Uses and Disclosures Not Requiring Your Written Authorization Your mental health information may be used and disclosed in the following ways.

- **Treatment:** Your mental health information may be used and disclosed in the provision and coordination of your healthcare. For example, this may include coordinating and managing your health care with other health care professionals. Your mental health information may be used and disclosed when I consult with another professional colleague, or if you are referred for medication, or for coverage arrangements during my absence. In any of these instances only information necessary to complete the task will be provided.
- **Payment:** Your mental health care information will be used to develop accounts receivable information, to bill you, and with your consent to provide information to your insurance company or other third party payer for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, dates and type of service, and other information about your condition and treatment, but will be limited to the least amount necessary for the purposes of the disclosure.
- **Health Care Operations:** Your mental health information may be used and disclosed in connection with our health care operations, including quality improvement activities, training programs and obtaining legal services. Only necessary information will be used or disclosed.
- **Required or Permitted by Law:** Your mental health care information may be used or disclosed when I am required or permitted to do so by law or for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or to take action regarding imminent danger to others; (d) when the client is a danger to self or others or gravely disabled; (e) when a coroner is investigating the client's death; or (f) to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, or regulatory compliance.
- **Contacting the Client:** You may be contacted to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.
- **Crimes on the premises or observed by the provider:** Crimes that are observed by the therapist or the therapist's staff, crimes that are directed toward the therapist or the therapist's staff, or crimes that occur on the premises will be reported to law enforcement.
- **Business Associates:** Some of the functions of the practice may be provided by contracts with business associates. For example, some of the billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.
- **Involuntary Clients:** Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.
- **Family Members:** Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of the discussion. However, if the client objects, protected health information will not be disclosed.
- **Emergencies:** In life threatening emergencies the practice will disclose information necessary to avoid serious harm or death.

Uses and Disclosures Requiring Your Written Authorization or Release of Information
Except as described above, or as permitted by law, other uses and disclosures of your mental health information will be made only with your written authorization to release the information. When you sign a written authorization, you may later revoke the authorization in writing as provided by law. However, that revocation may not be effective for actions already taken under the original authorization.

- **Psychotherapy Notes:** Psychotherapy notes are maintained separate from your mental health record. These notes will be used only by your therapist and disclosure will occur only under these circumstances: (a) the therapist who wrote the notes uses them for your treatment; or (b) they may be used for training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills; or (c) if you bring a legal action and we have to defend ourselves; and (d) certain limited circumstances defined by the law.

YOUR RIGHTS AS A CLIENT

Additional Restrictions: You have the right to request additional restrictions on the use or disclosure of your mental health information. However, the clinician does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. Ask your clinician for the Request Form for Protected Health Information.

Alternative Means of Receiving Confidential Communications: You have the right to request that you receive communications from the practice by alternative means or at alternative locations. For example, you may request that bills and other correspondence be sent to an address other than your home address. Ask your clinician for the Request Form.

Access to Protected Health Information: You have the right to inspect and obtain a copy of your protected health information in the mental health and billing record. However, any psychotherapy notes are for the use of your therapist, and are treated differently. If it is thought that access to your mental health records would harm you, your access may be restricted. Ask your clinician for the Request Form for PHI and the appeal process.

Amendment of Your Record: You have the right to request an amendment or correction to your protected health information. If the clinician agrees that the amendment or correction is appropriate, the Practice will ensure the amendment or correction is attached to the record. An appeal process is available if the clinician determines the record is accurate and complete as is. Ask your clinician for the Request Form PHI and the appeal process available to you.

Accounting of Disclosures: You have the right to receive an accounting of certain disclosures the practice has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures authorized by you, or disclosures made prior to April 14, 2003. Other exceptions will be provided to you, should you request an accounting. Ask your clinician for the Request Form.

Right to Revoke Consent or Authorization: You have the right to revoke your consent or authorization to use or disclose your mental health information, except for action that has already taken place under your consent or authorization.

Copy of this Notice: You have a right to obtain a copy of this Notice upon request.

The Practice is required to abide by the terms of this Notice, or any amended Notice that may follow. The Practice reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that it maintains. When changes are made, the revised Notice will be posted at the Practice's office and copies will be available upon request.

If you believe the Practice has violated your privacy rights, you may file a complaint with the person designated within the Practice to receive your complaints, [*that is your clinician or the Privacy Officer*]. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Bldg., Washington, D.C. 20201. It is the policy of the Practice that there will be no retaliation for your filing of such a complaint.

Chris Kalamon & Associates

Acknowledgement of Review of Notice of Privacy Rights

This Practice is required by State and Federal law to maintain the privacy of protected health information. In addition, the Practice is required by law to provide clients with access to the Notice of Privacy Practices explaining our legal duties and privacy practices with respect to your mental health information, and to request that you sign the below written acknowledgement that you reviewed a copy of this Notice. This Notice describes how the Practice may use and disclose your protected health information. This Notice also describes your rights regarding your protected health information and how you may exercise your rights. Please review the notice on the bulletin board before signing this acknowledgement. If you have any questions about this Notice or would like a copy, please contact Chris Kalamon.

I, _____, acknowledge that I reviewed a copy of the Notice of Privacy Practices
Client Name

for Chris Kalamon. (Guardian or parents must sign for clients 18 years and younger.)

_____ _____
Client Signature or Personal Representative Date

_____ _____
Client Signature or Personal Representative Date

_____
If you are not the client, please print name and state legal authority to sign for client.

----------*For Practitioner Use Only*----------

I attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining acknowledgement
- ❑ Client was incapable of signing
- ❑ Other (Specify)_____

_____

_____ _____
Signature of Practitioner Date