LIVING BALANCE

Partners in Counseling & Psychological Services

Brandie Brigham, LMFT

Except in cases of abuse to a minor or immediate danger to yourself/others, all information provided will be kept strictly confidential and released only in accordance with necessary professional ethics and state/federal law.

Date: _____Who can we thank for referring you to LIVING BALANCE?_____

Client's Name(s): _____SEX: M F Birth date:_____

_____SEX: M F Birth Date:_____

Address: _____City, State:_____ Zip: _____

Phone with area code Home: ( ) _____ Work: ( )_____

Cell: ( )_____ Email: _____

PLEASE CIRCLE PHONE NUMBERS AND/OR ADDRESS THATARE OK FOR COUNSELOR CONTACT. IF IT IS **NOT OK** TO USE ABOVE CONTACT INFORMATION, PLEASE GIVE OTHER ADDRESS AND/OR A PLACE TO RECEIVE MESSAGES BELOW:

Phone/Address for Counseling Staff use:_____
(if not listed above)

(If client is under 18: Parent's name(s): _____)

Employer(s): _____

Occupation: _____ For how long?_____

Marital/relationship status:_____ Spouse/partner's name: _____

Spouse/partner's date of Birth: _____ Spouse/partner's Occupation_____

Emergency Contact? Name: _____Phone: (____) _____

Relationship with Emergency Contact: _____

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INSURANCE INFORMATION

Patient's Name(s): _____SEX: M F Birthdate:_____

_____SEX: M F Birthdate:_____

Insurance Company_____ Phone Number (on card):_____

Policy Holder's Name:_____ Birthdate: _____

Policy Holder's SSN: _____ Policy Holder's ID #:_____

Group #:_____Deductible: $_____ Has it been met? Yes____ No___

Co-payment (amount not covered by your insurance for each visit): $_____

Who will pay balance that is NOT covered by insurance? _____

If you are required to get preauthorization, have you done so?_____ # visits authorized: _____

If you still need a preauthorization tell your counselor or LIVINGBALANCE Staff right now.

Other Insurance/Secondary Insurance

Secondary Insurance (if any): _____Phone Number (on card):_____

Policy Holder's Name:_____ Birth date: _____

Policy Holder's SSN: _____ Policy Holder's ID #:_____

Group #:_____Deductible: $_____ Has it been met? Yes____ No___

Copayment (amount not covered by your insurance for each visit): $_____

If you are required to get preauthorization, have you done so?_____ # visits authorized: _____

ALL PATIENTS USING HEALTH INSURANCE PLEASE SIGN BELOW.

I hereby grant authorization to my counselor:

(circle counselors name) Brandie Brigham, LMFT –
PHI or Protected Health Information (except Psychotherapy Notes), to my insurance company that is necessary for billing for my treatment or my insured family member's treatment, or to process my claim for payment of services.

I also authorize my stated counselor and their chosen contracted billing agency/agent, POMS of Boise to exchange my Protected Health Information in order to process an insurance claim, provide me with a monthly statement of my account, and facilitate reimbursement.

I authorize my insurance company to send payment directly to stated counselor at 1910 North Lakes, Meridian Idaho, for all services provided. I understand that stated counselor is a self contracted, solo practitioner and therefore, responsible for the appropriate and legal handling of my PHI. I also agree that a photocopy of this document shall be as valid as the original.

Insured /Client Signature_____ Date _____

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MEDICAL HISTORY

Primary Care Physician: _____

Current Physical Health: Poor ____ Unsatisfactory____ Satisfactory____ Good____ Very good____

Current Medications Prescribed to You	Dosages	Prescribing Doctor

Use the back of this page if more writing room is need. Make a note to "turn over."

Current Health (Diabetes, reasons currently under physicians care, physical pain, migraines):

_____

_____

_____

Past Health and Surgeries (Relevant Medical History which continues to affect you today):

_____

_____

_____

List all therapists you have seen, and approximate dates you saw them, including relationship counseling:

_____

_____

List any inpatient psychiatric treatment you have had, and the dates:

_____

_____

Have any members of your family had a history with:

Drugs ___ Alcohol ___ Depression ___ Anxiety ___ Bipolar Disorder___ Suicide ____Other ___

Problem	Who	Current Y / N	Past Y / N

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FAMILY INFORMATION

	Age	Name	Deceased (Y/N)
Mother	_____	_____	____
Father	_____	_____	____
Stepmother	_____	_____	____
Stepfather	_____	_____	____
Siblings	_____	_____	____

1) Did you (or do you if you are a minor) live in one house or two houses while growing up? _____

2) Did you experience academic problems in elementary through high school? None ___ Little___ Struggled___

3) List below who is currently living with you:

NAME	AGE	RELATIONSHIP	Are they Supportive? Y/N

4) In general, how often did you feel happy when you were growing up? Frequently___ Sometimes ____ Rarely____Never____

5) Who in your family or friends do you currently feel closest to? _____Relationship to them _____
Who are you most distant from? _____ In most conflict with? _____

6) If applicable, how long have you been in your current romantic relationship? _____

Please describe: Violent/Volatile ____Major problems____ Minor problems____ Satisfactory____ Very satisfactory____

7) Have you personally experienced emotional abuse? Frequently___ Sometimes ____ Rarely____ Never____

Abused as a Child ___ Abused as an Adult ___ Who is or was this person to you? _____

8) Have you personally experienced physical abuse? Frequently___ Sometimes ____ Rarely____ Never____

Abused as a Child ___ Abused as an Adult ___ Who was this person to you? Family, friend, stranger, etc. _____

9) Have you experienced sexual assault, unwanted sex or uncomfortable/unwelcome touching?

Frequently___ Sometimes ____ Rarely____ Never____

Abused as a Child ___ Abused as an Adult ___ Who was this person to you? Family, friend, stranger, etc. _____

10) Please share anything else in your family history or current situation that your counselor should know.

_____

_____

_____

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Alcohol and Substance Usage in the Past 6 months.

Your honesty is absolutely necessary for your treatment. *This information is confidential:*

Substance	Amount	Times/Week	Substance	Amount	Times/Week
Alcohol	_____	_____	**Mushrooms**	_____	_____
Marijuana	_____	_____	**Rx Pain Meds**	_____	_____
Cocaine or crack	_____	_____	**Xanax**	_____	_____
Methamphetamine	_____	_____	**Valium**	_____	_____
Pills Rx for me ie Ritalin	_____	_____	**Ecstasy**	_____	_____
LSD	_____	_____	**Other**_____	_____	_____

I use alcohol or drugs to (check all that apply): Manage stress __ To relax __ For a better mood __ For sleep __
Inpatient treatment for Substance Abuse? Yes No Date:

---

1) Have you personally experienced legal problems? No Yes Problem:_____

2) What kind of problem brings you to LIVINGBALANCE? _____

3) How would you estimate the severity of your problem? Mild ____ Moderate____ Serious ____ Severe ____

Who is affected by this problem? _____

4) **Think about your symptoms over the past 2 weeks and CHECK ALL THAT APPLY:**

__overeating	__ restless	__rapid heart rate	__compulsive behaviors
__relationship	__taking drugs	__ depressed mood	__sexual problems
__fears/phobias	__ crying without reason	__trembling/shaking	__daily anxiety
__weight loss/gain	__ difficulty concentrating	__shortness of breath	__vomiting after a meal
__memory problems	__ low motivation	__muscle tension/pain	__distrust of others
__social withdrawal	__ aggressive behavior	__uncontrolled anger	__jumpy
__family problems	__ feelings of worthlessness	__nightmares	__dizzy or lightheaded
__chest pain	__stomach problems/pain	__easily distracted	__fatigue/loss of energy
__can't fall asleep	__sleeping too much	__obsessions	__unwanted thoughts
__financial problems	__problems with school	__housing problems	__decreased need for sleep
__daily pain	__drinking alcohol	__traumatic event	__binging
__unhappy with job	__disinterested in sex	__suicidal thoughts	__want to harm/hurt myself
__poor body image	__harming family/others	__mood swings	__feel mentally disconnected
__financial crisis	__legal issues	__debilitating injuries	__psychiatric disorder
__other: _____		__ plan to harm self	

5) Please describe any incidents that may *have triggered and/or been associated* with the above

symptoms you marked (ie. relationship ending, etc.): _____

6) COPING: In the past, what has been helpful to you in dealing with this problem?

_____

7) Have you ever intentionally inflicted any harm upon yourself? Yes ____No ____Unsure____
Have you ever intentionally inflicted harm on someone else? Yes____ No____ Unsure____

8) Have you had suicidal thoughts recently? Frequently___ Sometimes ____ Rarely____ Never____
Have you had them in the past? Frequently___ Sometimes ____ Rarely____ Never ____
Has anyone related to you attempted/committed suicide? _____ If yes, their relation to you? _____

COUNSELING DISCLOSURE STATEMENT for **Brandie Brigham**

Welcome to LIVINGBALANCE: We are a group of self-contracted professionals practicing autonomously, yet working, sharing and growing professionally together. We want your experiences here to be positive and enlightening for you. This disclosure statement is to inform you about us and about your rights as a client. Please sign this form to verify that you have received this information. Take your time, read this carefully, and ask your counselor if you have any questions.

Brandie Brigham's credentials and education are as follows:

Idaho Licensed Clinical Professional Counselor #2770
Idaho Licensed Marriage and Family Therapist #2771
Masters Degree: Mental Health Counseling, Idaho State University
EFT Practitioner
Civil Mediator

Brandie Brigham's theoretical approach is eclectic with an emphasis in CBT techniques, establishing meaning and purpose, and mindfulness. She has received training and is experienced in practicing family, couples, group, individual, adolescent therapy, and playtherapy. She also has experience with an effective and efficient acupressure technique, pain management, and custody issues.

The Idaho Counselors Licensing Board has the general responsibility of regulating the practice of licensed professional counselors. The licensure of any individual under the licensing laws of Idaho does not imply or constitute and endorsement of the counselor nor guarantee effectiveness of treatment. The Idaho Counselor Licensing Board, through the Idaho Bureau of Occupational Licenses, Owyhee Plaza, 1109 Main Street, Suite 220, Boise, Idaho 83702.

Client Rights:

- Counseling is a voluntary act, and you have the right to choose counselors who best suit your needs. We will do our best to accommodate your needs or to give you an appropriate referral.
- You have the right to be treated ethically by your counselor. Counselors are required to adhere to the code of ethics adopted by the Idaho Counselor Licensing Board.
- Sexual Intimacy between a counselor and a patient is NEVER appropriate, and should be reported to the Idaho Counselor Licensing Board.
- If you have any questions concerning your rights and/or ethical treatment, or if you wish to file a complaint, please contact the Idaho Counselor Licensing Board.

Confidentiality Policy: ***If you have any questions about confidentiality, please talk to your counselor.***
The clinicians at LIVINGBALANCE observe confidentiality within the code of ethics written by the Idaho Counselor Licensing Board, National Board of Certified Counselors, HIPPA Guidelines, and state and federal law. To provide effective service, your therapist may discuss your case with others working in or for LIVINGBALANCE (i.e., other counselors, and/or the receptionist). However, no clinical information about you, beyond what is required for billing/reimbursement, is given to anyone outside of LIVINGBALANCE staff including parents, partners, roommates, employers, or teachers. ***The communication between counselor and client is privileged with the exception of the following (pursuant to Idaho Rule of Evidence 517-d),***

- ***We have your written permission***.
- ***It is necessary to notify appropriate authorities in order to prevent clear and imminent danger*** to you or others.
- You indicate that there is reasonable cause to believe that a child, dependent adult, or a vulnerable elderly ***person has been abused***.
- ***A court orders us to disclose*** confidential information about you. If this happens, we will first ask that the court reconsider their order. If they refuse to drop their order, we will disclose only the minimum amount of information we deem necessary to satisfy the court's order.
- ***You waive the privilege by bringing charges*** against us or initiate Licensing Board proceedings under *Idaho Code 54-3404.*
- ***There are proceedings for guardianship, conservator ship, or hospitalization.*** As to a communication relevant to an issue in proceedings for the appointment of guardian or conservator for a client for mental illness or to hospitalize the client for mental illness.
- ***Child related communications***. Ina criminal or civil action or proceeding as to a communication relevant to an issue concerning the physical, mental or emotional condition, of or injury to a child, or concerning the welfare of a child including but not limited to the abuse, abandonment, or neglect of a child.

Psychotherapy: Our goal is to provide consultation, evaluation, and counseling services for patients/clients dealing with issues impacting their well-being. We work with patients in exploring new approaches to the issues they are dealing with. This may include problem solving techniques, healthy decision making, and cognitive and behavioral strategies for coping and managing thoughts, feelings, and behaviors. Information about the experience, training, and approaches of our professional staff is available upon request.

Counseling Center Services: A range of options may be discussed following an assessment of the need for counseling services. Please inquire about current therapy/group offerings. Our services include:

- Individual counseling and Life Coaching
- Couples therapy
- Child/Adolescent
- Psycho-educational groups
- Pain Management
- Custody
- College Master Search, Preparation, Financial Aid
- Family Therapy
- Career Counseling
- Social Anxiety Treatment
- EFT (Acupressure; Techniques for emotional/physical pain)
- Education/Support for Alternative Parenting Techniques

LIVING BALANCE
Partners in Counseling & Psychological Services

Assignment to a Counselor: We will attempt to match you with a professional counselor who can best meet your needs. The Triage Clerk and/or Staff will consider which counselors can accommodate your counseling needs and insurance financial needs. Based on this information, assignments to counselors are made with consideration of appropriate fit and the availability of individual counselors. Those on a sliding fee scale will likely be treated by a counseling intern.

Training And Supervision of Counseling Interns: All interns are under the direct daily supervision of Counseling Center staff and will discuss your treatment plan and progress with their supervisor on a regular basis. If treated by an intern, you may be requested to allow your session to be video/audio taped. When a session is taped, interns may review the recordings or portions of the recordings with their supervisors, who will then discuss and provide feedback about their session. Once recordings have been reviewed, they will be erased. Prior to being reviewed, they will be stored in a locked area.

Because supervision is an important aspect of an intern's training, we encourage you discuss any concerns or questions about supervised counseling sessions with your counselor.

Contact From The Counseling Center: Please let the staff know of how to contact you while maintaining your privacy, if it is not in your listed contact information. After hours, voice mail is our preferred method of communication, since we cannot guarantee the confidentiality of anything sent through e-mail.

When Immediate Assignment is not Available:

• If your counselors have no open slots for seeing a client:
• You may be offered referrals to providers in the community to expedite the process of being seen.
• You may be placed on our waiting list, or both.
• If you have not heard back from us within two weeks after adding your name to the wait list, please check back with us.

The waiting list will be continually assessed. Once assigned to a counselor, we will attempt to contact you by phone twice. If we do not hear back from you after these attempts, we will remove you from the waiting list. Please let us know if you are on the waiting list and plan to be out of town. Also, please let us know if you are on the waiting list and no longer want our services.

Our Schedule and No Show/Late Cancel Policies:

Cancellation Policy and "No-Shows": As there is a high demand for our services and often a wait list, we require at least 24 hours notice if you need to cancel or reschedule your appointment.

IMPORTANT: If you "no-show" for your appointment (i.e., do not come in for your session), fail to cancel within 24 hours, or come more than 25 minutes late for the start of your session (in which case, you MAY not be seen), you will be billed a *$45.00 fe*e and this will be noted as a "no-show."

• In the event you miss an appointment, it is your responsibility to reschedule with us. If you "no-show" a scheduled appointment, you must contact our center and/or reschedule, the $45.00 No Show Fee will apply.
• If you "no-show" for two appointments during a two month period of time, your counselor will review your case for continued eligibility. Each counselor has their own limits on this issue, but please be aware you may or may not be eligible to continue based on the review.

I have read and fully understand the preceding description and conditions of LIVINGBALANCE COUNSELING services, procedures and policies. I agree to permit my counselor to discuss the nature of my problems with other Counseling Center Staff. I understand this Disclosure Statement and I consent to counseling. Additionally, I consent to the following:

• If I "no-show" for my appointment, fail to cancel within 24 hours, or arrive more than 25 minutes late for an appointment, I will not be seen, need to reschedule, and understand that **I will be billed $45.00.** After a missed appointment, I have one week to contact LIVINGBALANCE. If one week passes, I understand that the center will assume I no longer need their services.
• If I "no-show" for two appointments in two months, I understand that I my counselor will consider whether I am committed to continued counseling and may terminate the counseling relationship.
• It is my responsibility to notify the staff or my counselor at THE LIVINGBALANCE BUILDING if my contact information changes.
• I understand that if I am waiting to be assigned an appointment, two attempts to reach me will be made. I need to contact LIVINGBALANCE within 1 week or it will be assumed I am not interested in services.
• If I am on the waiting list and expect to be out of town, I will notify LIVINGBALANCE.
• I will notify the staff at LIVINGBALANCE if I no longer need or want their services.
• I understand the above information, and have received my own copy of this form for my review.

Client Signature: _____ Date: _____

** I need to communicate via email. I have asked the staff that I be contacted by email and I understand that the confidentiality of information transmitted via email cannot be guaranteed. Client initial here: _____

Counselor Signature: _____ Date: _____

LIVING BALANCE
Partners in Counseling & Psychological Services

FEE AGREEMENT AND CONTRACT FOR:

Brandie Brigham, LMFT, LCPC
Licensed Marriage and Family Therapist
Licensed Clinical Professional Counselor

1. **FEE:**
   The standard **fee will be 95.00 per 50 minute** individual, couples, or family session. Depending on insurance and other considerations, the initial fee for the first visit could be higher. Although health insurance may aid in payment, you alone are responsible for paying for psychological and counseling services and appointments with **Brandie Brigham** at LIVINGBALANCE. We are contracted with most insurance and EAP's and you will not be balance billed, but responsible for your co-payment.

   If you cancel or do not keep an appointment without giving twenty-four hours' advance notice, *you must pay $45 f*or the time you have reserved. Insurance companies do not pay for cancelled appointments.

   If you are ill and call in advance to cancel your appointment, and we are able to fill the appointment, there will be no charge.

If your insurance company requires you to get authorization from them before seeing a therapist and you do not do so, you agree to be responsible for full payment for services rendered and late fees if applicable.

2. **PAYMENT ARRANGEMENT: All accounts are payable in full within 30 days after billing. Overdue Accounts may be charged interest at the rate of 15% annually.**

_____ **STANDARD PAYMENT ARRANGEMENT: Payment for any deductible or noninsured portion of your fee is due prior to each session.**

_____ *ALTERNATIVE PAYMENT ARRANGEMENT only if agreed to by **Brandie Brigham** and client:

3. COLLECTIONS PROCEDURES: **Brandie Brigham** reserves the right to collect any unpaid balance if the account is 30 days or more past due and there is no current payment arrangement agreement. Monies owed and unpaid to **Brandie Brigham** may result in the use of a collection agency or legal action to secure payment, as authorized by state or federal law. The collections action will become a part of your credit record. Clients will be notified in writing before **Brandie Brigham** takes action to collect. In the event that client becomes delinquent and payment is not made on amounts owing under the terms of this agreement, and the balance is placed with a licensed collection agency, client agrees to pay the fees of the collection agency, which amount is theretofore agreed to be 50% of the outstanding balance at the time the account is placed for collections. The 50% collection agency fee will be calculated and added at the time the account is placed into collections.

4. LIMIT ON UNPAID BALANCE: **Brandie Brigham may terminate treatment and refer the client elsewhere for continued therapy if the unpaid balance exceeds $300.00.**

I have read and understood the above fee agreement, and I agree to abide by its terms.

Client/Responsible Party:_____ **Date:** _____

CONFIDENTIALITY AND FILES: NOTICE OF PRIVACY POLICIES AND PRACTICES

Federal and State laws governing confidentiality can be quite complex. This Notice explains some specific Patient Rights that you have under these laws. Each Clinician will maintain personal clinical files for the purpose of treatment and/or billing. Each Clinician maintains personal client files *which are not the property* of LIVINGBALANCE Counseling, L.L.C. You may examine and/or receive a copy of your file if you request it in writing and the request is signed and dated by you.

USES AND DISCLOSURES OF **PROTECTED HEALTH INFORMATION (PHI)** FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

LIVINGBALANCE Counseling may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. **"PHI"** refers to information in your health record that could identify you. "**Treatment, Payment and Health Care Operations**": **Treatment i**s when Clinicians at LIVINGBALANCE provide, coordinate and manage your health care and other services related to your health care**. Payment** is when Clinicians at LIVINGBALANCE obtain reimbursement for your healthcare. Your Clinician may use a collection agency, an accountant, clerical support, and a billing agency. As required by HIPAA, these businesses have signed contracts with us committing to maintain the confidentiality of **PHI** except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and a blank copy of the contract. **Health Care Operations** are activities that relate to the performance and operation of the Staff at LIVINGBALANCE. "**Use"** means activities within LIVINGBALANCE practiced such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. Your therapist practices with other mental health professionals, secretarial, and billing staff and needs to share information with secretarial/billing staff for purposes such as billing, scheduling, and quality assurance. Also, LIVINGBALANCE clinical staff routinely consults with each other concerning our clients. ***Please let your therapist know if you would prefer that other clinical staff not be consulted about your case***. All of the professional staff are bound by the same rules of confidentiality, and all secretarial/billing staff have training in privacy rules and have agreed not to release any information outside of the practice without permission of a professional staff member. **"Disclosure**" means activities outside of our office, such as releasing, transferring, or providing access to information about you to other parties. Your therapist may find it helpful to share information with your primary care physician or other health and mental health professionals who are currently treating you.

• **Uses and Disclosures Requiring Authorization:** Your therapist may use or disclose PHI for purposes outside of treatment, payment, and health care operations when authorization is obtained. An **"authorization**" is written permission above and beyond the general consent that permits only specific disclosures. When your therapist is asked for information for purposes outside of treatment, payment and health care operations, she/he will obtain an authorization from you before releasing this information. Your therapist will also need to obtain a separate authorization before releasing your psychotherapy notes. **"Psychotherapy notes**" are notes your therapist has made about your conversations during a private, group, joint, or family counseling session, which your therapist has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time. LIVINGBALANCE counselors reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that is maintained. LIVINGBALANCE will provide you with a revised notice by posting the revisions in the waiting room for your inspection. You may revoke authorization in writing. You may not revoke an authorization to the extent that (1) Your therapist has relied on that authorization; or (2) if the authorization was obtained as a condition of insurance coverage, and the law provides the insurer's right to contest the claim under the policy.

• **Uses and Disclosures with Neither Consent nor Authorization:** Your therapist may use or disclose PHI without your consent in the following circumstances:

o Child Abuse: If your therapist knows or suspects that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired person under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, she/he is required by law to report that knowledge or suspicion to Child Protection, or a municipal or county peace officer.

o Elder Abuse: If your therapist has reasonable cause to believe that an elder is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, she/he is required by law to immediately report such belief to the Idaho Department of Health and Welfare.

o Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by the therapist-client privilege law. LIVINGBALANCE Clinicians cannot provide any information without your (or your personal or legal representative's) written authorization. However, if a court orders your counselor to disclose information, we are required to provide it.

o Serious Threat to Health or Safety: If your therapist believes that you pose a clear and substantial risk of imminent serious harm to yourself or another person, she/he may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to your therapist an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and your therapist believes you have the intent and ability to carry out the threat, then she/he is required by law to take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s).

o Worker's Compensation: If you file a worker's compensation claim, your therapist may be required to give your mental health information to relevant parties.

o If the client is a minor: Parents have access to the minor client's complete Clinical Record, unless there is a court order prohibiting one or both of the parents from access.

o If a government agency (such as Medicare) is requesting the information for health oversight activities, LIVINGBALANCE may be required to provide it to them.

o If a client files a complaint or lawsuit against LIVINGBALANCE staff, the clinicians may disclose relevant information regarding that patient in order to defend themselves.

o Staff may present *disguised* case material in seminars, classes, or scientific writings: all identifying information and "PHI" is omitted and client anonymity is maintained.

o Your health insurance plan has the right to review your Clinical Records for any services you have asked them to pay for. Unless your treatment is being paid for by a Workers Compensation plan, a *health insurance company is not entitled to see Psychotherapy Notes*, which are detailed notes your therapist may make concerning what you have talked about in therapy. However, *they are entitled to see PHI in your clinical record*, including dates of therapy, symptoms, diagnosis, progress towards goals, any past treatment records received from other providers, professional consultation reports, your billing records, and any other reports including reports to your insurance carrier.

CLIENT'S RIGHTS AND THERAPIST'S DUTIES

CLIENT'S RIGHTS: Right to Request Restrictions–You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, your therapist is not required to agree to a restriction you request. **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, to keep your information private from our family, you can have your bills sent to an alternate address. **Right to Inspect and Copy**–You have the right to inspect and/or obtain a copy of your, or your minor child's, PHI and psychotherapy notes in your therapist's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. There will be a charge for records returned from remote/off site locations and for copies made. **Right to Amend**–You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your therapist may deny your request. **Right to an Accounting**–You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described on this Notice). **Right to a Paper Copy**–You have the right to obtain a paper copy of the Privacy Notice from your therapist upon request, even if you have agreed to receive the Notice electronically.

THERAPIST'S DUTIES: Your therapist is required by law to maintain the privacy of PHI and to provide you with a notice of their legal duties and privacy practices with respect to PHI. **LIVINGBALANCE reserves the right to change the privacy policies and practices described in this notice which will be posted in the waiting room**. Unless your therapist notifies you of such changes, however, the therapist is required to abide by the terms currently in effect.

COMPLAINTS: If you are concerned that your therapist has violated your privacy rights, or you disagree with a decision your therapist made about access to your records, you may contact the Idaho Board of Occupational Licenses. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS, AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE OF PRIVACY PRACTICES INCLUDED ABOVE.

Signature of client or responsible party _____ Date:_____

Witness_____