



# THE CENTER FOR LIVING BALANCE

## Client Information Form

Today's date: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Your name: \_\_\_\_\_  
Last First Middle

Home street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Address of Employer: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_

We have a mailing list, providing additional information and support to our clients. Would you like to join the Center for Living Balance mailing list?  Yes  No

Referred by: \_\_\_\_\_

- May I have your permission to thank this person for the referral?  Yes  No
- If referred by another clinician, would you like for us to communicate with one another?  Yes  No

Person(s) to notify in case of any emergency: \_\_\_\_\_  
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): \_\_\_\_\_

Please briefly describe your presenting concern(s): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your goals for therapy? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? \_\_\_\_\_

**MEDICAL HISTORY:**

Please explain any significant medical problems, symptoms, or illnesses: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medications:**

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day? \_\_\_\_\_

Do you consume caffeine? YES NO If YES, how much per day? \_\_\_\_\_

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? \_\_\_\_\_

Do you use any non-prescription drugs? (Please remember that this form is completely confidential). YES NO  
If YES, what kinds and how often? \_\_\_\_\_

Previous Hospitalizations: (Approximate dates and reasons): \_\_\_\_\_  
\_\_\_\_\_

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO

(Please list approximate dates and reasons): \_\_\_\_\_  
\_\_\_\_\_

**FAMILY:**

How would you describe your relationship with your mother? \_\_\_\_\_  
\_\_\_\_\_

How would you describe your relationship with your father? \_\_\_\_\_  
\_\_\_\_\_

Are you parent's still married or did they divorce? \_\_\_\_\_ If they divorced, how old were you when they separated or divorced, and how did this impact you? \_\_\_\_\_

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: \_\_\_\_\_  
\_\_\_\_\_

How many sisters do you have? \_\_\_\_\_ Ages? \_\_\_\_\_

How many brothers do you have? \_\_\_\_\_ Ages? \_\_\_\_\_

How would you describe your relationships with your siblings? \_\_\_\_\_  
\_\_\_\_\_

**RELATIONSHIP STATUS:**

Currently in Relationship? \_\_\_\_\_ How Long? \_\_\_\_\_ Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Married/Life Partnered? \_\_\_\_\_ How Long? \_\_\_\_\_ Previously Married/Life Partnered? YES NO

If so, length of previous marriages/committed partnerships \_\_\_\_\_

Do you have children? \_\_\_\_\_ If YES, how many and what are their ages: \_\_\_\_\_

Describe any problems any of your children are having: \_\_\_\_\_  
\_\_\_\_\_

PLEASE CHECK ALL THAT APPLY & **CIRCLE** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST
Anxiety →				People in General →				Nausea →		
Depression				Parents				Abdominal Distress		
Mood Changes				Children				Fainting		
Anger or Temper				Marriage/Partnership				Dizziness		
Panic				Friend(s)				Diarrhea		
Fears				Co-Worker(s)				Shortness of Breath		
Irritability				Employer				Chest Pain		
Concentration				Finances				Lump in the Throat		
Headaches				Legal Problems				Sweating		
Loss of Memory				Sexual Problems				Heart Palpitations		
Excessive Worry				History of Child Abuse				Muscle Tension		
Feeling Manic				History of Sexual Abuse				Pain in joints		
Trusting Others				Domestic Violence				Allergies		
Communicating with Others				Thoughts of Hurting Someone Else				Often Make Careless Mistakes		
Drugs				Hurting Self				Fidget Frequently		
Alcohol				Thoughts of Suicide				Speak Without Thinking		
Caffeine				Sleeping Too Much				Waiting Your Turn		
Frequent Vomiting				Sleeping Too Little				Completing Tasks		
Eating Problems				Getting to Sleep				Paying Attention		
Severe Weight Gain				Waking Too Early				Easily Distracted by Noises		
Severe Weight Loss				Nightmares				Hyperactivity		
Blackouts				Head Injury				Chills or Hot Flashes		

**FAMILY HISTORY OF (Check all that apply):**

Drug/Alcohol Problems				Physical Abuse				Depression			
Legal Trouble				Sexual Abuse				Anxiety			
Domestic Violence				Hyperactivity				Psychiatric Hospitalization			
Suicide				Eating Disorder				“Nervous Breakdown”			

**Any additional information you would like to include:**

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## INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

Welcome to **The Center for Living Balance**. We are pleased that you selected our facility for your therapy, and we are sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from your therapist or group leader, policies regarding confidentiality and emergencies, and other details regarding your treatment at **The Center for Living Balance**. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with your therapist or group leader is a collaborative one, and we welcome any questions, comments, or suggestions regarding your course of therapy at any time.

### Background Information, Theoretical Views, & Client Participation

Josh Gebhardt is contract therapist at The Center for Living Balance, working under the direction of Amy Jaynes, LPC, NCC, CRC and the supervision of Kelly Petaccio, LPC, CPCS. He received his undergraduate degree in Finance from Georgia Southern University and his master's degree in Marriage and Family Therapy from Lee University. He has advanced training in Emotionally Focused Therapy for Couples (EFT), Gottman Level I Couples Therapy, and Trauma Focused Cognitive Behavior Therapy (TF-CBT). The majority of his current work is focused on relationships—including marriage and couples counseling and family counseling. Additional information regarding Josh's educational background and experience may be found on our website under his name. Please feel free to view that information at [www.centerforlivingbalance.com](http://www.centerforlivingbalance.com).

It is our belief that as people become more aware accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with your therapist/group leader at any point.

In order for therapy to be most successful, it is important for you to take an active role. This means working on the things you and your therapist talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is our policy to only see clients who we believe have the capacity to resolve their own problems with our assistance. It is our intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without your therapist. We also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, your therapist will direct you to other resources that will be of assistance to you. Your personal development is our number one priority. We encourage you to let us know if you feel that transferring to another facility or another therapist is necessary at any time. Our goal is to facilitate healing and growth, and we are very committed to helping you in whatever way seems to produce maximum benefit. If at any point you are unable to keep your appointments or we don't hear from you for one month, we will need to close your chart. However, reopening your chart and resuming treatment is always an option.

If you are seeking services for your minor child, you and the other parent/guardians will meet with your therapist for an initial intake appointment without the minor child. This allows the therapist to collect necessary information and get a clear understanding of your goals of the therapeutic process. Please bring any custody documents, divorce decrees, or other formalized parenting plans to the intake session. In cases of divorce and legal separation, we cannot provide treatment services without these legal documents.

## **Confidentiality & Records**

Your communications with your therapist will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked filing cabinet in our locked office. Additionally, our practice uses HIPAA Compliant electronic medical records software, called My Clients Plus and their scheduling software Jituzu. Our phone systems are HIPAA compliant software called Spruce. Our office also has a Business Service Agreement with Google to provide Gsuite services to our office in compliance with HIPAA. We use Square to process credit card transactions.

Your therapist will always keep everything you say to him or her completely confidential, with the following exceptions: (1) you direct your therapist to tell someone else and you sign a "Release of Information" form; (2) your therapist determines that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) your therapist is ordered by a judge to disclose information. In the latter case, your therapist's license does provide him or her with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a counselor. This state has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. We cannot guarantee that the appeal will be sustained, but we will do everything in our power to keep what you say confidential.

Please note that in relationship (couples or family) counseling, your therapist does not agree to keep secrets. Information revealed in any context may be discussed with any party involved in treatment. Additionally, these records are treated differently than individual counseling records. The relationship holds the confidentiality in these cases and all adult parties must sign consent to release information or records request form in the case of the need to consult or report data.

## **Structure and Cost of Services**

At your intake appointment, your therapist will work with you to assess your needs, level of care, symptoms, and goals. You will work together to develop a treatment plan based on your clinical needs. In general, your therapist agrees to provide psychotherapy at the fee schedule below:

### **Josh Gebhardt, MS, AMFT**

50 min individual counseling session - \$135.00

50 min couples/family counseling session - \$135.00

100 min counseling session - \$270.00

### **General Services**

Phone consultations between sessions - \$8.00/min

Form comp. (per 5 pages), letter writing - \$75.00

Returned check fee - \$50.00

Doing psychotherapy by telephone is not ideal and needing to talk to your therapist between sessions may indicate that you need extra support. If this is the case, you and your therapist will need to explore adding sessions or developing other resources you have available to help you.

The fee for each session will be due at the beginning of the session. Cash, personal checks, Visa, MasterCard, Discover, or American Express are acceptable for payment, and your therapist will provide you with a receipt of payment. The receipt of payment may also be used as a statement for insurance if applicable to you. Fees for missed or late-canceled appointments must be paid prior to scheduling future appointments.

Insurance companies have many rules and requirements specific to certain plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. Your therapist will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

## **Cancellation Policy**

In the event that you are unable to keep an appointment, you must notify your therapist at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. You will be billed the full session fee for any missed session without 24 hour notification. 24 hour notice for an

8:00am appointment would be 8:00am the previous business day. Monday appointments need to be canceled or changed by the scheduled appointment time on Friday. One exception to this policy per client is granted once per calendar year. All additional missed or late-canceled sessions will be billed at the full rate, regardless of circumstances.

### **In Case of an Emergency**

*The Center for Living Balance* is considered to be an outpatient facility, and we are set up to accommodate individuals, couples, and families who are reasonably safe and resourceful. We do not carry beepers nor are we available at all times. If at any time this does not feel like sufficient support, please inform your therapist, and he or she can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, your therapist will return phone calls within 24-48 hours. If you have a mental health emergency, we encourage you not to wait for a call back, but to do one or more of the following:

- Call Behavioral Health Link/GCAL: 800-715-4225
- Call Ridgeview Institute at 770.434.4567 or Piedmont Hospital Fayetteville at 770-719-7000
- Call Peachford Hospital at 770.454.5589
- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Call 911.
- Go to the emergency room of your choice.

### **Professional Relationship**

Psychotherapy is a professional service we will provide to you. Because of the nature of therapy, your relationship with your therapist has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and your therapist were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of our clients the best care, your therapist's judgment needs to be unselfish and purely focused on your needs. This is why your relationship with your therapist must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their clients confidential. As much as your therapist would like to, for your confidentiality he or she will not address you in public unless you speak to him or her first. Your therapist also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, your therapist will not be able to be a friend to you like your other friends. In sum, it is the duty of your therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

### **Statement Regarding Ethics, Client Welfare & Safety**

*The Center for Living Balance* assures you that our services will be rendered in a professional manner consistent with the ethical standards of the American Counseling Association. If at any time you feel that your therapist is not performing in an ethical or professional manner, we ask that you please let him or her know immediately. If the two of you are unable to resolve your concern, please contact one of the Clinical Co-Directors (Amy Jaynes, LPC and Deana Riley, LPC) at 770-451-0404.

Due to the very nature of psychotherapy, as much as we would like to guarantee specific results regarding your therapeutic goals, we are unable to do so. However, your therapist, with your participation, will work to

achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is our intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and your therapist are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

### **Technology Statement**

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to us that we maintain your confidentiality, respect your boundaries, and ascertain that your relationship with your therapist remains therapeutic and professional. Therefore, we've developed the following policies:

**Cell phones:** It is important for you to know that cell phones may not be completely secure and confidential. However, we realize that most people have and utilize a cell phone. Your therapist may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with your therapist.

**Text Messaging and Email:** Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to text and/or email because it is a quick way to convey information. If you choose to utilize texting or email, please discuss this with your therapist. **However, please know that it is our policy to utilize these means of communication strictly for appointment confirmations (nothing that anyone could infer as therapy).** Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. If you do, please know that your therapist will not respond. **You also need to know that we are required to keep a summary or a copy of all emails and texts as part of your clinical record that address anything related to therapy.**

**Facebook, LinkedIn, Instagram, Pinterest, Twitter, Etc:** It is our policy not to accept requests from any current or former client on social networking sites such as Facebook, LinkedIn, Instagram, Pinterest, etc. because it may compromise your confidentiality. *The Center for Living Balance* has a business Facebook page, Instagram account, and is on LinkedIn. You are welcome to follow us on any of these pages. However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to *The Center for Living Balance*. Please refrain from making contact with us using social media messaging systems such as Facebook Messenger or Twitter Direct Message. These methods have insufficient security, and we do not watch them closely. We would not want to miss an important message from you.

**Google, Bing, etc.:** It is our policy not to search for our clients on Google or any other search engine. We respect your privacy and make it a policy to allow you to share information about yourself to your therapist as you feel appropriate. If there is content on the Internet that you would like to share with your therapist for therapeutic reasons, please print this material out and bring it to your session.

**Blog:** We may post therapeutic content on our blog. If you have an interest in following our blog, you are welcome to. However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to The Center for Living Balance.

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Please feel free to ask questions, and know that we are open to any feelings or thoughts you have about these and other modalities of communication.

**Faxing Medical Records:**

If you authorize us (in writing) via a "Release of Information" form to send your medical records or any form of protected health information to another entity for any reason, we may need to fax that information to the authorized entity. It is our responsibility to let you know that fax machines may not be a secure form of transmitting information. Additionally, information that has been faxed may also remain in the hard drive of our fax machine. However, our fax machine is kept behind two locks in our office. And, when our fax machine needs to be replaced, we will destroy the hard drive in a manner that makes future access to information on that device inaccessible.

**Recommendations to Websites or Applications (Apps):**

During the course of our treatment, your therapist may recommend that you visit certain websites for pertinent information or self-help. She or he may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites and/or apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide and communicate to your therapist if you would like this information as adjunct to your treatment or if you prefer that your therapist does not make these recommendations.

**Our Agreement to Enter into a Therapeutic Relationship**

We are sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask your therapist.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with your therapist/group leader, and you are authorizing your therapist/group leader to begin treatment with you.

\_\_\_\_\_  
**Client Name (Please Print)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Client Signature**

**If Applicable:**

\_\_\_\_\_  
**Parent's or Legal Guardian's Name (Please Print)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent's or Legal Guardian's Signature**

The signature of the Therapist below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

\_\_\_\_\_  
**Therapist's Signature**

\_\_\_\_\_  
**Date**



# Notice of Privacy Practices

## Your Information. Your Rights. Our Responsibilities.

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.**

### Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

### Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

### Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

### Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

**Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### **Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

#### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

#### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

#### **Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

#### **Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

#### **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

#### **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

## **Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information:

- Marketing purposes
- Sale of your information
- Fundraising
- Most sharing of psychotherapy notes

## **Our Uses and Disclosures**

### *How do we typically use or share your health information?*

We typically use or share your health information in the following ways.

#### **Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

#### **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

#### **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

### *How else can we use or share your health information?*

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

#### **Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

#### **Do research**

We can use or share your information for health research.

#### **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

#### **Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

#### **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

## **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

## **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

## **Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

**Effective Date of this notice: November 28, 2016**

### *Receipt of HIPAA Notice*

Your signature below indicates that you have received, read, and understood the patient privacy practices of The Center for Living Balance. Please direct any questions or concerns that you have about this policy to your service provider.

\_\_\_\_\_  
Client Name

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Name of Parent or Guardian (if applicable)

\_\_\_\_\_  
Signature of Parent or Guardian (if applicable)

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Date Notice Received