THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND
DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS
NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information
about you that may identify you and that relates to your past, present or future physical or
mental health or condition and related health care services is referred to as Protected Health
Information (“PHI”). This Notice of Privacy Practices describes how we may use and disclose
your PHI in accordance with applicable law, including the Health Insurance Portability and
Accountability Act (“HIPAA”), regulations promulgated under HIPAA including the HIPAA
Privacy and Security Rules, and the NASW Code of Ethics. It also describes your rights
regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our
legal duties and privacy practices with respect to PHI. We are required to abide by the terms
of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of
Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI
that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy
Practices by posting a copy on our website, sending a copy to you in the mail upon request or
providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care
for the purpose of providing, coordinating, or managing your health care treatment and related
services. This includes consultation with clinical supervisors or other treatment team
members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment
services provided to you. This will only be done with your authorization. Examples of
payment-related activities are: making a determination of eligibility or coverage for insurance
benefits, processing claims with your insurance company, reviewing services provided to you
to determine medical necessity, or undertaking utilization review activities. If it becomes
necessary to use collection processes due to lack of payment for services, we will only
disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support
our business activities including, but not limited to, quality assessment activities, employee
review activities, licensing, and conducting or arranging for other business activities. For
example, we may share your PHI with third parties that perform various business activities
(e.g., billing or typing services) provided we have a written contract with the business that
requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will
be disclosed only with your authorization.
**Required by Law.** Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

**Without Authorization.** Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

**Child Abuse or Neglect.** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

**Judicial and Administrative Proceedings.** We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

**Deceased Patients.** We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

**Medical Emergencies.** We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

**Family Involvement in Care.** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

**Health Oversight.** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

**Law Enforcement.** We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

**Specialized Government Functions.** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for
national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing.

- Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a “designated record set”. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the
amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

**COMPLAINTS**

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257.
Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name: ______________________________________________

DOB: __________________________________________________________

SSN: ____________________________________________________________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Own Your Evolution, LLC’s Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Heather Tydings-Goldfarb of Own Your Evolution, LLC.

_______________________________________________________________
Signature of Patient/Client                                       Date

_______________________________________________________________
Signature or Parent, Guardian or Personal Representative          Date

‘ If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ Patient/Client Refuses to Acknowledge Receipt:

_______________________________________________________________
Signature of Staff Member                                         Date
CONFIDENTIALITY AGREEMENT

Information exchanged within our sessions is confidential and will be protected. Information will be shared outside of our sessions only with your written consent or in the event that a court of law demands it. However, the following are instances where I would be obligated by law to break our confidentiality agreement without your permission:

- If it is assessed during your participation in coaching sessions that abuse or neglect of children or elders is occurring;
- If you threaten to kill or harm another individual and I am convinced that you will act on this threat, or that you may lose control of your actions;
- If at any time during the course of our sessions, I determine that you are a danger to yourself, I will inform you of that opinion and make every effort to keep you from endangering your life. In some cases this may include, but not be limited to, notifying the police, emergency personnel, any medical personnel listed above and/or family members.

________________________________________________________________________________

Client (Signature)        Date

SHARED AGREEMENTS

- Payment is due at the time of service. I accept credit card or you may use PayPal. There is a link on my website www.rootingthroughgrief.com or go to PayPal directly (using email bonnie@rootingthroughgrief.com.)
- 50 minute sessions are billed at $130.00.
- A bill will be provided and client is responsible for seeking reimbursement through their insurance company.
- A full session fee will be charged for any missed or cancelled appointments with less than 24 hours notice. Inclement weather and true emergency's are exceptions.
- Lateness on the part of the client does not alter the session fee or ending time of the session. Lateness on the part of the therapist will always be made up.
• Fees may change in the future and clients will be notified 30 days in advance.

Insurance:

As a Licensed Clinical Social Worker, my professional services qualify for patient reimbursement under most insurance plans and are considered to be within the usual and customary range set by most insurance companies.

Although the choice to use your insurance for reimbursement of therapy is yours, please consider the following before making this decision:

• Insurance companies are designed to reimburse for the treatment of illness. Therefore, a psychiatric diagnosis is usually required before any reimbursement.
• Managed care companies control many facets of your therapy, including the medical necessity of care, the type of therapy they will cover, and the duration and pace of therapy.
• All insurance companies require some personal information in order to facilitate processing your claim. Once this information is transmitted to an insurance company, there is no way of ensuring that it will remain private and confidential.

Because I value confidentiality and believe that your therapy should be guided by you and not your insurance company, I do not participate in any managed care plans.

Please sign below to indicate that you have read and agree to the above, and will honor these shared agreements and agree to pay your fees for service.

_____________________________________________________________________________________

Client Signature           Date
Intake Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Name: ______________________________________________________________

(Last)    (First)    (Middle Initial)

Name of parent/guardian (if under 18 years):

(Last)    (First)    (Middle Initial)

Birth Date: _____ /_____ /_____ Age: ________ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children/age: ______________________________________________

Address: ______________________________________________________________

(Street and Number)
Home Phone: May we leave a message? □ Yes □ No

Cell/Other Phone: May we leave a message? □ Yes □ No

E-mail: ___________________________ May we email you? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): ___________________________

Emergency Contact and relationship to you: ___________________________

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ Yes, previous therapist/practitioner: ___________________________

Are you currently taking any prescription medication?

□ Yes, Please list:

Have you ever been prescribed psychiatric medication?

□ Yes, Please list and provide dates:

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

1. How would you rate your current physical health? (please circle)

Poor    Unsatisfactory    Satisfactory    Good    Very good

Please list any specific health problems you are currently experiencing:

2. How many times per week do you generally exercise? _______

What types of exercise to you participate in?
3. Are you currently experiencing overwhelming sadness, grief, or depression? 

If yes, for approximately how long? ________________________________

4. Are you currently experiencing anxiety, panic attacks, or have any phobias?

If yes, when did you begin experiencing this? __________________________

5. Do you drink alcohol more than once a week? □ No □ Yes

6. Do you engage recreational drug use? If so, how often do you use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

7. What significant life changes or stressful events have you experienced recently?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle & List Family Member(s)

• Alcohol/Substance Abuse yes/no
• Anxiety yes/no
• Depression yes/no
• Domestic Violence yes/no
• Eating Disorders yes/no
• Obsessive Compulsive Behavior yes/no
• Schizophrenia yes/no
• Suicide Attempts yes/no

Comments:

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

________________________________________________________________________

Do you enjoy your work? Is there anything stressful about your current work?

________________________________________________________________________

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

________________________________________________________________________

3. What would you like to accomplish out of your time in therapy/coaching?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Client Name (Printed): _____________________________________

Client Signature: __________________________________________ Date: _______