# DIMENSIONS FAMILY THERAPY

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# Parent Intake Form

In order for us to be able to fully evaluate your child or teenager, please fill out the following intake form (as they pertain to your child) to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; do the best you can. Any questions that require additional space to answer, please note on question and finish the answer on the back. If there is information you do not want in your child's or teenager's medical chart, it is ok to refrain from putting it in this form. Thank you!

**CHILD'S OR ADOLESCENT'S INFORMATION**

Patient's Name: _____ SS# _____-_____-_____ Sex: ☐ Male ☐ Female

Home Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: (_____) _____ Cell Phone: (____) _____ E-mail: _____

School: _____ Grade: _____ Date of Birth: _____ Age: _____

Religion: _____ Active member? ☐ Yes ☐ No Race/Culture/Ethnicity: _____

**PARENT'S INFORMATION**

**Mother's (Guardian's) Name**: _____ Date of Birth: _____ Age: _____

Home Phone: (_____) _____Cell Phone: (_____) _____

Employer (School, if student): _____ Work/School Phone: (_____) _____

Employer/School Address: _____

City: _____ State: _____ Zip code: _____

E-mail: _____ Occupation: _____ ☐ Student

Religion: _____ Active member? ☐ Yes ☐ No Race/Culture/Ethnicity: _____

**Father's (Guardian's) Name**: _____ Date of Birth: _____ Age: _____

Home Phone: (_____) _____Cell Phone: (_____) _____

Employer (School, if student): _____ Work/School Phone: (_____) _____

Employer/School Address: _____

City: _____ State: _____ Zip code: _____

E-mail: _____ Occupation: _____ ☐ Student

Religion: _____ Active member? ☐ Yes ☐ No Race/Culture/Ethnicity: _____

**REFERRAL SOURCE** _____

Address _____ Phone # (_____) _____

Do we have permission to release information to the referring professional when it is appropriate? Yes__ No__

**Give a brief summary of the main problems that brought you to seek evaluation:**

_____
_____
_____
_____
_____

**What are your goals for your child, adolescent and/or family in being here?**

_____
_____
_____

**Current Life Stresses for your Child:** (Please check all that apply and briefly describe)

☐ Relationships: _____
_____

☐ School: _____
_____

☐ Work (if applicable): _____
_____

☐ Other(s): _____
_____

**Prior counseling or psychiatric help:**

☐ **Individual Counseling:**
If yes, when and where? What were the issues? Did you feel that this helped?

_____
_____

☐ **Group Counseling:**
If yes, when and where? What were the issues? Did you feel that this helped?

_____
_____

☐ **Hospitalizations:**
If yes, when and where? What were the issues? Did you feel that this helped?

_____
_____

**CHILD'S DEVELOPMENTAL HISTORY**

**Prenatal and Birth Events:** (Please check all that apply)

Parents' attitudes toward the pregnancy ☐ Unplanned ☐ Planned ☐ Difficulty getting pregnant _____

Pregnancy complications: ☐ Bleeding ☐ Excess vomiting ☐ Medication ☐ Infections ☐ X-rays ☐ Smoking
☐ Alcohol/drug use ☐ Other: _____

Birthing complications: ☐ Trauma ☐ Forceps ☐ Other: _____

**Postnatal Period:**

Birth weight _____ Length _____ Labor duration _____ Delivery: ☐ Vaginal ☐ C section

APGAR scores (if known) _____ Any jaundice? : ☐ Yes ☐ No Time in hospital _____

☐ Complications: _____

Mother's health after delivery: _____

Post delivery blues? ☐ Yes ☐ No _____ If yes, how long? _____

Primary caretaker for child, first year: _____

Thereafter: _____

**Feeding History:** ☐ Breast ☐ Bottle Age weaned _____

☐ Food allergies/Drug intolerances: _____
☐ Current eating problems: _____
Current Height _____ Current Weight _____ Change in weight in past 3 months_____ Meals per day _____

**Toilet Training:**
Age reached bowel control: Day _____ Night _____ Age reached bladder control: Day _____ Night _____
Methods used: _____
Ease: ☐ Successful ☐ Unsuccessful, Please describe: _____
Current function: _____

**Motor Development:** (Please write in age, parentheses are approximate average age limits)

| | | | |
|---|---|---|---|
| Rolls over (3-5 months) | | Runs well (2 years) | |
| Sits without support (5-7m) | | Rides tricycle (3y) | |
| Crawls (5-8 m) | | Throws ball overhand (4 y) | |
| Walks well (11-16 m) | | Other | |

Current level of activity: ☐ Below average ☐ Average ☐ Above average
Fine and gross motor coordination: ☐ Below average ☐ Average ☐ Above average
Compared to peers: ☐ Below average ☐ Average ☐ Above average

**Language Development:** (Please write in age, parentheses are approximate average age limits)

| | | | |
|---|---|---|---|
| Several words- besides dada, mama (1y) | | Vocabulary | |
| Names several objects- ball, cup (15m) | | Articulation | |
| 3 words together- subject, verb, object (24m) | | Comprehension | |

Compared to peers: ☐ Below average ☐ Average ☐ Above average
☐ Current problems (Please describe) _____

**Social Development:** (Please write in age, parentheses are approximate average age limits)

| | | | |
|---|---|---|---|
| Smile (2m) | | Separates from mother easily (2-3y) | |
| Shy with strangers (6-10m) | | Cooperative play with others (4y) | |

Please briefly describe the following:
Quality of attachment to mother: ☐ Good ☐ Fair ☐ Poor _____
Quality of attachment to father: ☐ Good ☐ Fair ☐ Poor _____
Relationships to family members: ☐ Good ☐ Fair ☐ Poor _____
Early peer interactions: ☐ Good ☐ Fair ☐ Poor _____
Current peer interactions: ☐ Good ☐ Fair ☐ Poor _____
Special interests/hobbies: _____

**Emotional Development:** (Please briefly describe the following)
Early temperament: _____ Special objects (blankets, dolls, etc.) _____
Current personality: _____ Current Mood: _____
Fears/Phobias: _____ Habits: _____
Ability to express of feelings: ☐ Good ☐ Fair ☐ Poor (Please describe) _____

**Sexual Development: (If applicable)** (Answer only as much as you feel comfortable)
Age of first sexual experience: _____ Number of sexual partners: _____ Currently sexually active: ☐ Yes ☐ No
History of sexually transmitted disease: ☐ Yes ☐ No If yes, describe: _____
History of abortion: ☐ Yes ☐ No If yes, describe: _____
History of sexual abuse, molestation or rape: ☐ Yes ☐ No If yes, describe: _____
Current sexual problems: ☐ Yes ☐ No If yes, describe: _____
Gender identity issues: ☐ Yes ☐ No If yes, describe: _____

**History of Behavior and Discipline:**
Lying: ☐ Yes ☐ No If yes, describe: _____

Stealing: ☐ Yes ☐ No If yes, describe: _____

Rule breaking: ☐ Yes ☐ No If yes, describe: _____

**Legal Problems:** ☐ Yes ☐ No If yes, describe: _____

☐ Other: (Please describe) _____

| **Methods of Discipline** | **Effectiveness** |
|---|---|
| | |
| | |
| | |
| | |

**History of Sleep Behavior:**

☐ Nightmares: _____

☐ Recurrent dreams: _____

☐ Getting up: _____

☐ Going to bed: _____

☐ Other: _____

**Drug and Alcohol History: (If applicable)** (Please check all that apply)

| **Substance** | **Yes** | **No** |
|---|---|---|
| Alcohol (liquor, beer, wine, etc.) | | |
| Barbiturates (marijuana, hash, etc.) | | |
| Prescription sedatives or sleeping pills | | |
| Opiates (prescription pain killers heroin, codeine, morphine, etc.) | | |
| Amphetamines (diet pills, crystal meth/crank/ice, cocaine/crack, etc.) | | |
| Steroids | | |
| Inhalants (glue, gasoline, cleaning fluids, etc.) | | |
| Hallucinogens (LSD, mescaline, mushrooms, PCP, etc.) | | |

If you answered yes to any of the following, please answer the questions below:

Age when use began: _____ Current usage: _____

Withdrawal symptoms (if any): _____

Use of alcohol or drugs first thing in the morning: ☐ Yes ☐ No

**Caffeine use**: ☐ Yes ☐ No

If yes, describe: _____

**Smoking or Nicotine use**: ☐ Yes ☐ No

If yes, describe: _____

**School History:** (Please check all that apply)

Current grade: _____ Last grade completed: _____ Last school attended: _____

Average grades: _____ Number of schools attended _____ School Contact: _____

List the following **(if applicable)**: (Please be specific)

☐ Homework problems: _____

_____

☐ Learning disabilities: _____

_____

☐ Learning strengths: _____

_____

☐ Behavior problems: _____

_____

Briefly describe what teachers have said about the child/teen: _____

_____

**Employment History: (If applicable)** (Please check all that apply)

☐ Work related problems: _____

Previous performance appraisal/review from a supervisor: ☐ Good ☐ Average ☐ Poor

**Significant Developmental Events:** (Please check all that apply and briefly describe)

☐ Marriages: _____

☐ Separations: (Specify Age, Duration, and Reaction to separation): _____

_____

☐ Divorces: _____

☐ Deaths/Losses: _____

☐ Traumatic events: _____

_____

☐ Abuse (Physical, Sexual, Emotional): _____

_____

☐ Illnesses: _____

☐ Other: _____

_____

**Family Structure:**

| Name | Age | Relationship | Problems and/or Strengths in Relationship | Currently lives in household |
|---|---|---|---|---|
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |

**Family History:**

| | Mother | Father | Other Biological Relatives |
|---|---|---|---|
| **Age** | | | N/A |
| **Occupation** | | | N/A |
| **Marital Status** | | | N/A |
| **Last grade completed** | | | N/A |
| **Learning problems (specify)** | | | |
| **Behavior problems (specify)** | | | |
| **Alcohol/Drug use history** | | | |
| **Abuse history (verbal, physical, or sexual)** | | | |
| **Psychiatric problems** | | | |
| **Depression** | | | |
| **Anxiety** | | | |
| **Suicide Attempts** | | | |
| **Psychiatric hospitalizations** | | | |
| **Medical Problems** | | | |

**Medical History**

| Medication | Dosage | Start Date | End Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Physical History | Yes | No | Describe Date, Place, Cause, and/or Outcome |
|---|---|---|---|
| Head trauma | | | |
| Seizures or seizure-like activity | | | |
| Spaciness or confusion | | | |
| Prior hospitalizations | | | |
| Prior abnormal lab tests, X-rays, EEG, etc. | | | |

**Please bring school report cards and any state, national or special testing that has been performed. Thank you.**

# Medical Review of Systems

Please place a check mark in the boxes that apply. Explain any problem areas.

## General

- ❑ Being overweight
- ❑ Recent weight gain or weight loss
- ❑ Poor appetite
- ❑ Increased appetite
- ❑ Abnormal sensitivity to cold
- ❑ Cold sweats during the day
- ❑ Tired or worn out
- ❑ Hot or cold spells
- ❑ Abnormal sensitivity to heat
- ❑ Excessive sleeping
- ❑ Difficulty sleeping
- ❑ Lowered resistance to infection
- ❑ Flu-like or vague sick feeling
- ❑ Sweating excessively at night
- ❑ Urinating excessively
- ❑ Excessive daytime sweating
- ❑ Excessive thirst
- ❑ Other_____

## Neurological

- ❑ Pacing due to muscle restlessness
- ❑ Forgotten periods of time
- ❑ Dizziness
- ❑ Drowsiness
- ❑ Muscle spasms or tremors
- ❑ Impaired ability to remember
- ❑ "Tics"
- ❑ Numbness
- ❑ Convulsions / fits
- ❑ Slurred speech
- ❑ Speech problem (other)
- ❑ Weakness in muscles
- ❑ Other_____

## Respiratory

- ❑ Asthma, wheezing
- ❑ Cough
- ❑ Coughing up blood or sputum
- ❑ Shortness of breath
- ❑ Rapid breathing
- ❑ Repeated nose or chest colds
- ❑ Other_____

## Chest and Cardiovascular

- ❑ Ankle swelling
- ❑ Rapid / irregular pulse
- ❑ Breast tenderness
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Other_____

## Head, Eye, Ear, Nose, & Throat

- ❑ Facial pain
- ❑ Headache
- ❑ Head injury
- ❑ Neck pain or stiffness
- ❑ Frequent sore throat
- ❑ Blurred vision
- ❑ Double vision
- ❑ Overly sensitive to light
- ❑ See spots or shadows
- ❑ Hearing loss in both ears
- ❑ Ear ringing
- ❑ Disturbances in smell
- ❑ Runny nose
- ❑ Dry mouth
- ❑ Sore tongue
- ❑ Other_____

## Gastrointestinal and Hepatic

- ❑ Trouble swallowing
- ❑ Nausea or vomiting (throwing up)
- ❑ Abdominal (stomach / belly) pain
- ❑ Anal itching
- ❑ Painful bowel movements
- ❑ Infrequent bowel movements
- ❑ Liquid bowel movements
- ❑ Loss of bowel control
- ❑ Frequent belching or gas
- ❑ Vomiting blood
- ❑ Rectal bleeding (red or black blood)
- ❑ Jaundice (yellowing of skin)
- ❑ Other_____

## Musculoskeletal

- ❑ Back pain or stiffness
- ❑ Bone pain
- ❑ Joint pain or stiffness
- ❑ Leg pain
- ❑ Muscle cramps or pain
- ❑ Other_____

## Skin, Hair

- ❑ Dry hair or skin
- ❑ Itchy skin or scalp
- ❑ Easy bruising
- ❑ Hair loss
- ❑ Increased perspiration
- ❑ Sun sensitivity
- ❑ Other_____

## Genitourinary

- ❑ Itchy privates or genitals
- ❑ Painful urination
- ❑ Excessive urination
- ❑ Difficulty in starting urine
- ❑ Accidental wetting of self
- ❑ Pus or blood in urine
- ❑ Decreased sexual desire
- ❑ Other_____

**Females**

- ❑ No menses
- ❑ Menstrual irregularity
- ❑ Painful or heavy periods
- ❑ Premenstrual moodiness, irritability, anger, tension, bloating, breast tenderness, cramps, headache
- ❑ Painful menstrual periods
- ❑ Painful intercourse or sex
- ❑ Sterility infertility
- ❑ Abnormal vaginal discharge

Other_____

**Males**

- ❑ Impotence (weak male erection)
- ❑ Inability to ejaculate or orgasm
- ❑ Scrotal pain
- ❑ Abnormal penis discharge

Other_____

## Explanation

_____
_____
_____
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_____

**INFORMED CONSENT**

Welcome to the practice. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you have so we can discuss them. Once you sign this, it will constitute a binding agreement between us as well as your consent for us to begin therapy/treatment.

**COUNSELING SERVICES**

We offer a variety of services including the following: individual counseling/therapy, group counseling/therapy, psychological assessment, consultation, academic tutoring services, and other adjunctive services. Others may be added under the discretion of Dimensions Family Therapy. The types of services offered are subject to change without notice. These services are provided for families, individuals, couples, adolescents and children. The type of mental health therapy that we generally prefer is called Cognitive Behavioral. This approach to change emphasizes both how we think and what we do. As we learn new and different ways to look at current situations, we eliminate undesirable, unhealthy feelings and behaviors.

As counselors, we do not provide any medication or perform any medical treatments. If medication seems indicated, a psychiatrist can be consulted. We maintain close working relationships with a number of physicians and psychiatrists, and will refer you to these practitioners if needed.

When we work with people, one of the goals is to help them identify the underlying thoughts that are associated with undesirable feelings, actions, and behaviors. Unfortunately, there are no guarantees, and there are potential risks. Risks may include experiencing uncomfortable levels of feelings like sadness, anxiety, anger, frustration, etc., and people may recall unpleasant aspects of their personal history. People also sometimes report feeling worse before feeling better.

At any time during our work together, you have the right to decide to end treatment, and there is no moral, legal, or financial obligation other than to pay for the services already rendered. If you are thinking about ending therapy, we encourage you to discuss this with us, and if you wish, we will be glad to provide you with the names of other mental health providers.

**OFFICE HOURS**

Office hours vary according to clients' needs and scheduled meetings. Meetings are scheduled Monday through Friday, 8:00 a.m. until 7:00 p.m. First appointments generally last about an hour, and subsequent sessions are 45 minutes, although extended appointments are available. In the event that an appointment is scheduled outside of these times, we reserve the right to apply an after-hour charge. In the event of extremely bad weather, such as ice and snow, it is advisable to call just to make sure the office is open.

If an emergency situation arises for which the client and/or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in their community by dialing 911. One of our therapists will follow up with standard counseling and support to the client and/or family.

**TELEPHONE CALLS**

We strive to return telephone calls between sessions which is one reason sessions are 45 minutes. We are not interrupted during sessions for incoming calls. Generally, we do not believe that the telephone is the best manner to deal with therapy issues, and telephone calls that exceed five minutes may be charged at the normal therapy fees.

**PROFESSIONAL FEES**

| **Appointment** | **Licensed Professional Clinical Counselor-Doctorate** | **Licensed Professional Clinical Counselor-Masters** | **Licensed Professional Counseling Associate** |
|---|---|---|---|
| First Appointment (approx. 60 minutes) | $140.00 | $110.00 | $80.00 |
| 25 minutes | $60.00 | $45.00 | $35.00 |
| 45 minutes | $110.00 | $85.00 | $55.00 |
| 80 minutes- for families and couples | $165.00 | $125.00 | $90.00 |

| Group Session | Fee per Session |
|---|---|
| 1 hour | $25 |

*All fees are subject to change, and in the event of fee changes, you will be notified at least 30 days prior to such changes. These fees are for professional counselors. Other services will be billed at a different rate.

**BILLING AND PAYMENT POLICY**

You will be expected to pay for each session at the time it is held, unless previously agreed. Payment schedules for other professional services will be agreed to at the time these services are requested. Payment may be made by cash, personal check or credit card (American Express, MasterCard or Visa). There is a $25.00 service charge on all returned checks. Patients are expected to maintain a zero balance and accounts need to stay current in order to maintain ongoing treatment.

**Appointment Cancellation Policy:** Dimensions Family Therapy requires that cancellations for scheduled appointments be received 24 hours in advance during regular office hours (Monday through Friday 8:00am to 5:00pm). **Unkept or cancelled appointments that do not follow this policy will be charged an unkept appointment fee at the discretion of your therapist or doctor**. This fee can equal but will not exceed the therapist/doctors fee for the time originally scheduled. Insurance companies do not pay for unkept appointment fees and the patient/responsible party is held fully accountable for this charge.

Our office does not send patients statements on a regular basis. We will provide patients with receipts that may be submitted to insurance carriers for reimbursement. Patients and/or Responsible Parties are responsible for all charges whether or not they are covered by insurance. If additional time beyond the scheduled time is taken to assist patients, there will be a charge for the amount of time used. In addition, patients are charged for time spent with a patient on the telephone and time taken to write reports or correspondence on the patient's behalf. Reports for insurance, including treatment plans, will be billed at the hourly rate. If inpatient treatment is provided, fees are billed at the hourly rate, as well as any extended sessions or consultations.

If your account is more than 60 days in arrears and suitable arrangements for payment have not been agreed to, I reserve the right to forward your account to GLA Collections. If legal action is necessary, the costs of bringing that proceeding will be included in the claim and the client or responsible party will be responsible for all costs of collection, litigation, and attorney's fees. In such cases, the only information that is released about a client's treatment would be the client's name, the nature of the services provided (e.g., individual therapy), dates of services, and the amount due.

**INSURANCE**

Dimensions Family Therapy does not file insurance claim forms at this time, and we are not Medicare providers. Adjunctive services may be handled differently. Please see your therapist for additional information.

**LEGAL MATTERS**

Should we become involved in any legal matter such as giving testimony, depositions, etc., the fee is $300.00 per hour for preparation, review of materials, travel time, court time, and any other time involved. A retainer fee based on the estimated time involved will be paid in advance of any work. A minimum charge of $600.00 for the above work will be assessed.

**CONFIDENTIALITY**

Within the limitations discussed below, the information you reveal during our professional relationship will be kept confidential and will not be released to anyone without your written consent. However, certain conditions do require that confidentiality and privileged communication be breached including: (1) if you present a danger to yourself; (2) if you present an imminent danger to another person which can include a communicable disease that can be life-threatening to others; (3) if there is reason to believe that child abuse or neglect is present, a report must be filed with a state child protection agency; (4) if the treatment is ordered or under the supervision of the court; (5) an insurance company or managed care company requires you to consent to release of records and/or information to them as a condition for reimbursement and (6) information necessary for case supervision and consultation. When such is released, we cannot control how the information is treated, nor will Dimensions Family Therapy or its representatives be responsible for any injury or claim for damages arising from the release of records or information as required by the insurance company or managed care organization. In order to provide clinical coverage when your therapist is out of town, it may be necessary for that therapist to release general information to the licensed counselors, associates and psychiatrists who are covering.

Information revealed in marital therapy is protected by privileged communication in Kentucky and requires permission of both to waive. When working with couples, we adopt a "no secrets" rule. That is, should we speak individually with either party (e.g., via telephone), we reserve the right to disclose any information to the other party if we believe such information is relevant to the therapy process. If parents/guardians request or require that they are informed of the issues discussed in individual sessions, we require that the discussion occur in the presence of the child or adolescent.

**SPECIAL NOTES**

When a family is confronted by parental separation or divorce, it is very hard on everyone. It is important then when working as a couple, each person feels safe to speak openly and honestly, without fears that material revealed in therapy will be revealed in court and used in a negative fashion. In order to provide a safe environment for couples work, it is important that you agree not to call us as witness or to attempt to subpoena records in the event you choose to pursue divorce. While a judge may overrule this agreement and issue a court order for information, your signature(s) below reflect your agreement not to call us as a witness nor attempt to subpoena records.

In the unlikely event that Dimensions Family Therapy is unable to provide ongoing services, another provider will be arranged for those services and they will maintain your records for a period of 7 years.

**AGREEMENT**

I have read this information fully and completely, I have discussed any questions I had about the information, and I understand the information. I understand that there are no guarantees stated or implied, and I accept the risks inherent in the course of therapy. I have familiarized myself with the fees and charges for services provided by Dimensions Family Therapy, and I understand and agree that the counseling services rendered will be charged to me and not to any third-party payer. I acknowledge responsibility for payment of services, and I understand I am responsible for all costs of collection and litigation together with attorney's fees if the charges for services must be collected by an action of law. No one can predict the course of human relationships, and as we learn more about each other, it may be necessary to amend prior agreements.

Client Signature: _____ Date: _____

**Complete the following for clients under 18 years of age:**

I, _____, give permission for a therapist from Dimensions Family Therapy
(Name of parent/guardian)
to conduct counseling with my _____ , _____.
(Relationship) (Name of minor)

Parent/Guardian's signature: _____ Date: _____

Minor's signature: _____ Date: _____

## HIPPA NOTICE OF PRIVACY PRACTICES

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

**Effective date: July 1, 2008**

Dimensions Family Therapy has been and will always be totally committed to maintaining clients' confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

**Uses and disclosures of your health information are for the purposes of providing services.** Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

**TREATMENT** We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. This could include consultants and potential referral sources.

**PAYMENT** If insurance claims are made for adjunctive services, the information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes may be shared with the appropriate affiliate. We also may bill the person in your family who pays for your insurance.

**HEALTHCARE OPERATIONS** We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

**CONFIDENTIALITY**

Within the limitations discussed below, the information you reveal during our professional relationship will be kept confidential and will not be released to anyone without your written consent. However, certain conditions do require that confidentiality and privileged communication be breached including: (1) if you present a danger to yourself; (2) if you present an imminent danger to another person which can include a communicable disease that can be life-threatening to others; (3) if there is reason to believe that child abuse or neglect is present, a report must be filed with a state child protection agency; (4) if the treatment is ordered or under the supervision of the court; (5) an insurance company or managed care company requires you to consent to release of records and/or information to them as a condition for reimbursement and (6) information necessary for case supervision and consultation. When such is released, we cannot control how the information is treated, nor will Dimensions Family Therapy or its representatives be responsible for any injury or claim for damages arising from the release of records or information as required by the insurance company or managed care organization. In order to provide clinical coverage when your therapist is out of town, it may be necessary for that therapist to release general information to the licensed counselors, associates and psychiatrists who are covering.

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## HIPPA CLIENT RIGHTS

**Right to request how we contact you**

It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way.

May we contact you at home and/or leave a voicemail? ☐ Yes ☐ No
May we contact you at work and/or leave a voicemail? ☐ Yes ☐ No
May we contact you by cell phone and/or leave a voicemail? ☐ Yes ☐ No
May we contact you by email? ☐ Yes ☐ No
If no, where may we contact you? _____

**Right to release your medical records**

You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at anytime. However, a revocation is not valid to the extent that we acted in reliance on such authorization.

**Right to inspect and copy your medical and billing records**

You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstances, we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

**Right to add information or amend your medical records**

If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request within 60 days, or in some cases, within 90 days. Under certain circumstances, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

**Right to an accounting of disclosures**

You may request an accounting of disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information that we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years prior and after July 1, 2008, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

**Right to request restrictions on uses and disclosures of your health information**

You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

**Right to complain**

If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

**Right to receive changes in policy**

You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the Office Manager.

**AGREEMENT**

I have read the HIPPA Notice of Privacy Practices and Client Rights fully and completely. I have discussed any questions I had about the information, and I understand the information.

Client Signature: _____ Date: _____

**Complete the following for clients under 18 years of age:**

I, _____, have read the HIPPA Notice of Privacy Practices and Client Rights fully and completely.
(Name of parent/guardian)
I have discussed any questions I had about the information, and I understand the information.

Parent/Guardian's signature: _____ Date: _____

Minor's signature: _____ Date: _____