



Welcome,

Thank you for selecting NW Medical Hypnosis, LLC. I am looking forward to meeting you on your first visit. I have included some "First Session Guidelines" to help you prepare for that visit. Please feel free to call or email me if you have any other questions. Thank you!

First Session Guidelines

1. Download the New Client Forms from www.NWMedicalHypnosis.com website. There is a Forms button on the home page. At the top of the Forms page you will see the New Client Packet to download (file folder icon). The client packet is a single PDF file that contains instructions, disclosures, and forms. Print, fill out the forms, and bring them with you to the session. Feel free to make copies of any of the forms for your files.
2. Parking is at the front of the building off of 7th Avenue, or around the north side of the building in the underground lot. Once inside the building you can take the stairs or the elevator to the third floor. As you exit the elevator, Executive Suite 330 is immediately to your right, through the double doors. There is no receptionist.
3. There is a small waiting area inside Suite 330. Please make yourself comfortable and I will be out to greet you at the appointment time. On occasion the session before you may run a little over. Please be understanding and know that I will be with you as soon as possible.
4. The restrooms and drinking fountain are in the foyer area as you exit the elevators.
5. To promote a comfortable environment in my small office space, please refrain from wearing perfumes and cologne to your appointment. If you need to smoke before coming, please consider smoking at least 15-30 minutes before entering the building. Please remember, my office is a fragrance-free zone!
6. If you need to have a small snack during your appointment to maintain blood sugar levels, please feel free to bring something with you.
7. Since this is your time to focus on the reason for your visit, I request cell phones to be silenced or turned off for the duration of the session.
8. If you have any further questions you may contact me at 360-513-9567 or email at DebNesbittARNP@gmail.com.

Directions to NW Medical Hypnosis, LLC

From Portland

- I-5 North to Washington
- Take the NE 99th Street Exit (Exit 5)
- Left at Bottom of Exit Ramp onto NE 99th Street
- Right on NE 7th Avenue (traffic light by Chevron station)
- Left into parking lot for the H.H. Hall building (behind Chevron)
- Main entrance is on SW corner of building
- Suite 330-D is on the third floor - go to the right off the elevator

From Camas

- Highway 14 West to I-5 North
- I-5 North to the NE 99th Street Exit (Exit 5)
- Left at Bottom of Exit Ramp onto NE 99th Street
- Right on NE 7th Avenue (traffic light by Chevron station)
- Left into parking lot for the H.H. Hall building (behind Chevron)
- Main entrance is on SW corner of building
- Suite 330-D is on the third floor - go to the right off the elevator

From Seattle

- I-5 South to the NE 99th Street Exit (Exit 5)
- Right at Bottom of Exit Ramp onto NE 99th Street
- Right on NE 7th Avenue (traffic light by Chevron station)
- Left into parking lot for the H.H. Hall building (behind Chevron)
- Main entrance is on SW corner of building
- Suite 330-D is on the third floor - go to the right off the elevator



Initial Intake Form

Client Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell: (____) _____ Work: (____) _____

Email address: _____

Martial Status: Single Married Partnered Divorced Widowed

Date of Birth: ____ / ____ / ____ Occupation: _____ Nbr of Children: ____

People in your household: _____

Religious / Spiritual Preferences: _____

Emergency Contact: _____ Phone: (____) _____

Relationship to Patient: _____

Primary Care Provider: _____ Phone: (____) _____

Psychologist / Counselor: _____ Phone: (____) _____

Previous Experience with: Hypnosis / NLP Relaxation Breathing EFT / EMDR CBT
 Meditation Music / Art Therapy Biofeedback DBT

How did you learn about NW Medical Hypnosis, LLC?

DEX Yellow Book Zip Local Internet Other: _____

Referred by: _____

Would you like to receive the monthly NW Medical Hypnosis, LLC Newsletter? Yes No

Would you like to receive periodic updates ,offerings, and announcements from NW Medical Hypnosis, LLC ? Yes No

Reason for Visit: _____

Desired Outcome: _____

Are you currently experiencing or have a history of the following (check all that apply)

Past	Current		Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Inability to Relax
<input type="checkbox"/>	<input type="checkbox"/>	ADD / ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	<input type="checkbox"/>	Addictions	<input type="checkbox"/>	<input type="checkbox"/>	Lack of Energy
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares
<input type="checkbox"/>	<input type="checkbox"/>	Anger	<input type="checkbox"/>	<input type="checkbox"/>	Obsessive-Compulsive Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Pain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Panic Attacks
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Phobias: _____
<input type="checkbox"/>	<input type="checkbox"/>	Bi-polar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Poor Memory
<input type="checkbox"/>	<input type="checkbox"/>	Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Poor Self Esteem
<input type="checkbox"/>	<input type="checkbox"/>	Bruxism	<input type="checkbox"/>	<input type="checkbox"/>	PTSD
<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems
<input type="checkbox"/>	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Affective Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia
<input type="checkbox"/>	<input type="checkbox"/>	Dissociative Identify Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Grief / Loss	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal Thoughts / Attempts
<input type="checkbox"/>	<input type="checkbox"/>	Hair Pulling	<input type="checkbox"/>	<input type="checkbox"/>	Teeth Grinding
<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____

List conditions for which you are currently being treated:

Medical / Psychological: _____

List all medications including herbal and vitamin supplements. Include additional page if necessary:

Medication / Supplement	Dosage & Frequency	Reason for Taking



NW Medical Hypnosis, LLC

Debbie Nesbitt, MSN, ARNP, PMHNP-BC
10000 NE 7th Ave, Ste 330-D, Vancouver, WA. 98685
(360) 513-9567 DebNesbittARNP@gmail.com



Consent to Use and Disclose Your Protected Health Information

This form is an agreement between you, and me (Debbie Nesbitt, ARNP) and will become a part of your permanent medical record. When we use the words “you” and “your” below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

When I examine, test, diagnose, treat, or refer you, I will be collecting what the law calls “protected health information” (PHI) about you. I need to use this information in my office to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let me use your PHI and to send it to others for the purposes described above. **Your signature below acknowledges that you have read or heard my notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.**

To help insure protecting your privacy, please indicate below the preferred ways I may contact you, understanding that messages may contain information about, but not limited to, your treatment, care, payment, and appointments. In giving permission to contact you using one or more of the options outlined below you understand and acknowledge that there may be risks and limitations involved that preclude complete protected exchange of private and/or sensitive information. Selection of one or more contact options indicates agreement on your part that you release myself and NW Medical Hypnosis, LLC from all liability due to unforeseen errors due to transmission methods that do not provide total privacy and security of information. Check the communication options that I can use to contact you:

- Home Phone Cell Phone Work Phone Email Mail to home address

If you do not sign this form agreeing to these privacy practices, I cannot treat you. In the future, I may change how I use and share your information, and so I may change the notice of privacy practices. If I do change it, you can get a copy from my website, www.nwmedicalhypnosis.com, or by calling me at 360-513-9567.

If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. However, if I do agree, I promise to do as you asked. After you have signed this consent, you have the right to revoke it by presenting your request to me in writing. I will then stop using or sharing your PHI, but I may already have used or shared some of it, and I cannot change that.

Signature of client or personal representative

Date

Printed name of client or personal representative

Relationship to the client

Description of personal representative’s authority

Signature of authorized NW Medical Hypnosis, LLC Representative

Date

Copy given to or offered and refused by the client/representative



NW Medical Hypnosis, LLC

Debbie Nesbitt, MSN, ARNP, PMHNP-BC
10000 NE 7th Ave, Ste 330-D, Vancouver, WA. 98685
(360) 513-9567 DebNesbittARNP@gmail.com



Professional Disclosure Statement with Consent to Treatment

Contact Information: NW Medical Hypnosis, LLC, Debbie Nesbitt ARNP, PMHNP-BC, ABMH located at 10000 NE 7th Avenue, Suite 330-D, Vancouver, WA, 98685.

Phone number: 360-513-9567

Website: www.NWMedicalHypnosis.com

Registrations: Washington State: Advanced Registered Nurse Practitioner (Family Psychiatric Mental Health), Registered Nurse, Registered Hypnotherapist.

Education and Training: I hold a Master of Science Degree in Nursing from Gonzaga University and am licensed as an Advanced Registered Nurse Practitioner. I am ANCC board certified as a Family Psychiatric Mental Health Nurse Practitioner. I also have an Applied Science Degree in Nursing and an Associate's Degree from Clark College.

I have received hypnosis education, training and certification from a number of sources including the American Society of Clinical Hypnosis (ASCH), Oregon Society of Clinical Hypnosis (OSCH), and Apositiva in Portland, Oregon. I am certified in Neuro-Linguistic Programming (NLP), HypnoBirthing®, Hypnosis for Fertility, Complementary Medical Hypnosis, Meta States, and Pain Management. I hold a certificate of completion for Emotional Freedom Technique (EFT) and have been trained in the use of biofeedback.

I have passed the prestigious American Board of Medical Hypnosis exam and hold the highest level of certification available within the American Society of Clinical Hypnosis (Diplomate status). Through ASCH I am certified in Clinical Hypnosis and recognized as an Approved Consultant.

As the state of Washington has not adopted educational and training standards for the practice of hypnotism, this statement of hypnosis training is for informational purposes only. Hypnotism is a self-regulating profession and its practitioners are not licensed by most state governments.

I practice within the scope and standards of practice for advanced registered nurse practitioners. I maintain a high level of expertise through regular participation in a variety of professional courses, conferences, and professional organizations. I am required to have 45 continuing education credits every two years to maintain my advanced practice license.

Professional Memberships: I am a member in good standing of the American Psychiatric Nurses Association, American Holistic Nurses Association, American Society of Clinical Hypnosis, and the Oregon Society of Clinical Hypnosis (serving as President for 2010-2012).

My Philosophy & Approach: As a holistic nurse practitioner, I see my patients as unique and valuable individuals, with whom I partner together in treating the whole person; mind, body, spirit, and energy. I use a strengths-based, personal, one-on-one, client-oriented approach to help each patient identify core problems, and more importantly, to work together on solutions to help them achieve their goals. Utilizing principles from evidence-based therapies such as psychodynamic psychotherapy, interpersonal psychotherapy, cognitive behavioral therapy, hypnotherapy, and pharmacological interventions, I seek to create a safe, healing environment in which the patient can discover and explore those modalities which will best meet their needs. I offer hypnosis, NLP, EFT, biofeedback, counseling, and stress management services. Medication management is offered in the context of a holistic treatment plan, including therapy with review of diet, exercise, sleep, supplements, stress management, and personal support.

Therapy and Hypnosis Services: The primary objective of treatment is self-improvement and increasing quality of life. You, as the patient, are actively involved in the process and ultimately responsible for the number of sessions and the changes you wish to make. As we work together, there may be exercises for practicing new skills, reading assignments, and homework assigned to be done outside of session time which you are responsible for. ***I cannot and do not guarantee or promise any specific outcomes from our work together.***

By the end of the first or second session, *after completing an assessment*, I will share with you my thoughts about your case and collaborate with you on how we should proceed, including an approximate number of sessions, and if we are a good fit to work together. If we both mutually agree, after the assessment, that this is a good fit, then you will be accepted as my patient. If not, I will do what I reasonable can to help you find the appropriate practitioner. In everyone's best interest, I do not take on clients I do not think I can help. At any time I may refer you to other practitioners for additional allopathic or complementary services that I do not offer.

The process of ending therapy, called "termination," can be a very valuable part of our work. Stopping therapy should not be done casually, although either of us may decide to end it if we believe it is in your best interest. You are ultimately responsible for choosing the provider and treatment modality which best suits your needs and you always maintain the right to refuse services at any time. If you wish to stop therapy, I ask that you agree now to talk with me first so we can plan for termination in a way that is most helpful and supportive while coordinating transfer of services to another provider.

Treatment Consent: My services may include a psychiatric mental health evaluation, evaluation of lifestyle, diet, nutrition, sleep habits, substance use, physical activity, relationships, work, spiritual practices, and hobbies in light of how they impact health, collaboratively developing a treatment plan to attain mutually agreed upon goals, initiation of interventions including both pharmacological and non-pharmacological to make progress toward your goals, and re-evaluation of interventions at appropriate intervals.

While I will seek to do everything I can to maintain therapeutic progress, it is dependent on several factors, some of which are out of my control. Conditions under which treatment may be terminated include but are not limited to:

- Inability to establish and maintain a therapeutic relationship.
- Lack of progress toward therapeutic goals.
- With-holding of information deemed necessary to the therapeutic process.
- Engaging in substance use/abuse or other activities destructive to the therapeutic process
- Failure to follow treatment plan
- Failure to keep follow-up appointments, two consecutive missed/no show appointments
- Failure to keep account balance current
- Using prescribed medications in any illegal manner
- Hostile or aggressive behavior deemed unsafe for the ARNP, staff, or other patients.

Risks & Benefits: All hypnosis is considered self-hypnosis. It involves narrowing your scope of focus. In this state of focused attention an individual may be highly responsive to suggestion. Hypnosis, counseling, and therapy can bring up negative feelings, emotions and memories. There are times when symptoms may actually appear to worsen before they improve. The change process may disrupt relationships, work or school. It is important for you to immediately communicate with me throughout the therapeutic process and share any questions or concerns you have.

There are many potential benefits of therapy that have been reported in hundreds of well-designed research studies for a variety of issues such as anxiety, depression, phobias, and trauma. Benefits may include resolving past issues or trauma, reducing anxiety or depression, and improving quality of life. I will share with you the risks and benefits for the specific treatment options and medications we discuss so you can make an informed decision if this treatment is the right choice for you.

Patient Rights and Responsibilities:

As my patient, you have the right to:

- Be treated with respect, free of physical, verbal and sexual abuse or discrimination.
- A copy of the acts of unprofessional conduct as listed in RCW18.130.180 which is provided in the 'Counseling and Hypnotherapy Clients' handout on my website: www.nwmedicalhypnosis.com.
- Know the estimated duration of treatment and approximate cost before treatment begins.
- Terminate treatment at any time; I will help with transfer of care to another practitioner.
- Assert any right without fear of retaliation.
- Understand risks and benefits for receiving or refusing treatment.
- Be assured your personal health information is handled confidentially as outlined in the "Notice of Privacy Practice" handout you received, read, understood, and signed.

As my patient, you have the responsibility to:

- Keep all appointments as scheduled.
- Commit to your therapy and treatment plan by following through on all homework assignments, exercises, and if applicable following medication management instructions.
- Pay in full each session (cash, check, VISA, MasterCard) unless other arrangements have been preapproved, as I do not bill insurance. I will provide a receipt.
- Let me know 48 hours in advance for appointment cancellations otherwise you will be billed \$115. No shows are also billed \$115. These fees will be due within two weeks of the originally scheduled appointment or by the next appointment, whichever comes first.
- Let me know at any time questions or concerns you have regarding any aspect of your treatment so I can work toward a satisfactory resolution.
- Make sure you have enough medications between appointments to prevent running out. Regular medication check appointments will be scheduled to monitor desired effects, review side effects, make dosage adjustments, and write prescription refills.
- Update me with changes in contact information, medical/psychological health conditions, ability to pay for services.

Crisis & Emergencies: I check my phone and email messages throughout the day, Monday through Friday, 8-5pm, with the exception of weekends, holidays, and scheduled vacations. Due to the nature of working with patients, I may not be able to answer your call immediately but will try to get back to you as soon as possible, usually within the same working day.

If your situation is urgent and you are unable to reach me, you should call your primary care provider, the Clark County Crisis Line at (360) 696-9560, Washington County Crisis Line at (503) 291-9111, or dial 911. You can also go directly to the emergency department of the nearest hospital. For medication questions you may consult your pharmacist, physician, or 911.

There may be times when I am out of the office on vacation or leave, that I will have another ARNP or Psychiatrist covering for emergencies. If that is the case, I will leave a contact phone number on my answering machine. Your signing of this document gives me permission to share your health information with this provider during my absence. They are also bound to the same privacy laws that I am.

If you are having an allergic reaction to medication such as skin rash, hives, itching, swelling, or difficulty breathing or swallowing, stop taking the medication and seek medical attention immediately.

Fees: The initial assessment appointment is \$250. Follow-up appointments are \$125 per hour.

Medication checks combined with therapy are \$50 in addition to the hourly appointment cost.

Follow up medication checks are \$75 (maximum 30 minutes).

Smoking cessation sessions are \$350 and include an initial session, a follow-up session, handouts, and two self-hypnosis CD's for ongoing reinforcement and support.

Classes are priced separately and are payable at the beginning of the class. See website for class schedules and prices. Prices are subject to change without notice.

Payment options include cash, check, or credit card (VISA, MasterCard). An additional \$4 processing charge is applied to all credit card payments. A receipt will be provided. I do not bill insurance, Medicare, or Medicaid. Patients with out-of-network benefits may seek reimbursement using provided receipts.

All fees are subject to change without notice.

Cancellation & Rescheduling Policy: No problem for appointments that are cancelled or rescheduled with at least 48 hours notification. No-shows or appointments changed with less than 48 hours notice will be billed for a one hour appointment at the current hourly appointment rate. Please let me know if there are extenuating circumstances which result in a missed appointment. These fees will be due within two weeks of the originally scheduled appointment or by the next appointment, whichever comes first.

Confidentiality: Health care information is protected by law and requires your authorization for disclosure except for information needed to facilitate treatment planning, payment, or health care operations. The law also mandates I release information in the following circumstances without your permission: cases of suspected child/elder abuse, imminent danger to self or others, and subpoena for legal proceedings. You will find a copy of the "Notice of Privacy Practices" in your New Patient Intake Packet and on my website at www.nwmedicalhypnosis.com under "forms". Please read it carefully.

After receiving, read/have read to you, and been given an opportunity to ask questions, please initial indicating that you are of sound mind, understand the material given, agree to, and are signing voluntarily:

- _____ New Patient Intake Form
- _____ Notice of Privacy Practices
- _____ Consent to Use and Disclose Your Protected Health Information
- _____ Professional Disclosure Statement with Consent to Treatment

By signing below, I request and consent to engage in treatment with Debbie Nesbitt, ARNP, PMHNP-BC, understanding this will be a holistic approach, including but not limited to, the services and therapies referred to in this document. I have discussed any concerns about the treatment process and I agree to the contract terms as stated above.

Client Name: (print) _____

Client Signature or representative: _____ Date: _____

ARNP Signature: _____ Date: _____



Notice of Privacy Practices (Full Version)

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.

Privacy is a very important concern for all those who come to this office. It is also complicated, because of the many federal and state laws and our professional ethics. Because the rules are so complicated, some parts of this notice are very detailed, and you probably will have to read them several times to understand them. If you have any questions, I will be happy to help you understand my procedures and your rights.

Contents of this notice

- A. Introduction: To my clients
- B. What I mean by your medical information
- C. Privacy and the laws about privacy
- D. How your protected health information can be used and shared
 1. Uses and disclosures with your consent
 - a. The basic uses and disclosures: For treatment, payment, and health care operations
 - b. Other uses and disclosures in health care
 2. Uses and disclosures that require your authorization
 3. Uses and disclosures that don't require your consent or authorization
 - a. When required by law
 - b. For law enforcement purposes
 - c. For public health activities
 - d. Relating to decedents
 - e. For specific government functions
 - f. To prevent a serious threat to health or safety
 4. Uses and disclosures where you have an opportunity to object
 5. An accounting of disclosures I have made
- E. Your rights concerning your health information
- F. If you have questions or problems

A. Introduction: To our clients

This notice will tell you how I handle your medical information. It tells how I use this information here in this office, how I share it with other professionals and organizations, and how you can see it. I want you to know all of this so that you can make the best decisions for yourself and your family. If you have any questions or want to know more about anything in this notice, please ask me for more explanations or more details.

B. What I mean by your medical information

Each time you visit me or any doctor's office, hospital, clinic, or other health care provider, information is collected about you and your physical and mental health. It may be information about your past, present, or future health or conditions, or the tests and treatment you got from me or from others, or about payment for health care. The information I collect from you is called "PHI," which stands for "**protected health information.**" This information goes into your **medical or health care records** in my office.

In this office, your PHI is likely to include these kinds of information:

- Your history: Things that happened to you as a child; your school and work experiences; your marriage and other personal history.
- Reasons you came for treatment: Your problems, complaints, symptoms, or needs.
- Diagnoses: These are the medical terms for your problems or symptoms.
- A treatment plan: This is a list of the treatments and other services that I think will best help you.
- Progress notes: Each time you come in, I write down some things about how you are doing, what I notice about you, and what you tell me.
- Records I get from others who treated you or evaluated you.
- Psychological test scores, school records, and other reports.
- Information about medications you took or are taking.
- Legal matters.
- Billing and insurance information

There may also be other kinds of information that go into your health care records here.

I use PHI for many purposes. For example, I may use it:

- To plan your care and treatment.
- To decide how well the treatments are working for you.
- When we talk with other health care professionals who are also treating you, such as your family doctor or the professional who referred you to me.
- To show that you actually received services from me, which I billed to you or to your health insurance company, although currently I am not billing insurance.
- For teaching and training other health care professionals.
- For medical or psychological research.
- For public health officials trying to improve health care in this area of the country.
- To improve the way I do my job by measuring the results of our work.
- When you understand what is in your record and what it is used for, you can make better decisions about who, when, and why others should have this information.

Although your health care records in my office are my physical property, the information belongs to you. You can read your records, and if you want a copy I can make one for you (but I may charge you for the costs of copying and mailing, if you want it mailed to you). In some very rare situations, you cannot see all of what is in your records. If you find anything in your records that you think is incorrect or believe that something important is missing, you can ask me to amend (add information to) your records, although in some rare situations I don't have to agree to do that. If you want, I can explain more about this.

C. Privacy and the laws about privacy

I am required to tell you about privacy because of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requires me to keep your PHI private and to give you this notice about my legal duties and my privacy practices. I will obey the rules described in this notice. If I change my privacy practices, they will apply to all the PHI I keep. We will also post the new notice of privacy practices in my office where everyone can see. You or anyone else can also get a copy from me at any time. It is also posted on www.nwmedicalhypnosis.com.

D. How your protected health information can be used and shared

Except in some special circumstances, when I use your PHI in this office or disclose it to others, I share only the **minimum necessary** PHI needed for those other people to do their jobs. The law gives you rights to know about your PHI, to know how it is used, and to have a say in how it is shared. So I will tell you more about what I do with your information.

Mainly, I will use and disclose your PHI for routine purposes to provide for your care, and I will explain more about these below. For other uses, I must tell you about them and ask you to sign a written authorization form. However, the law also says that there are some uses and disclosures that don't need your consent or authorization.

1. Uses and disclosures with your consent

After you have read this notice, you will be asked to sign a separate **consent form** to allow me to use and share your PHI. In almost all cases I intend to use your PHI here or share it with other people or organizations to provide treatment to you, arrange for payment for my services, or some other business functions called "health care operations."

In other words, I need information about you and your condition to provide care to you. You have to agree to let me collect the information, use it, and share it to care for you properly. Therefore, you must sign the consent form before I begin to treat you. **If you do not agree and consent I cannot treat you.**

- a. The basic uses and disclosure: For treatment, payment, and health care operations. Next I will tell you more about how your information will be used for treatment, payment, and health care operations.

For treatment. I use your medical information to provide you with psychological treatments or services. These might include individual, family, or group therapy; psychological, educational, or vocational testing; treatment planning; or measuring the benefits of our services. I may share your PHI with others who provide treatment to you. I am likely to share your information with your personal physician. If you are being treated by a team, I can share some of your PHI with the team members, so that the services you receive will work best together. The other professionals treating you will also enter their findings, the actions they took, and their plans into your medical record, and so we all can decide what treatments work best for you and make up a treatment plan. I may refer you to other professionals or consultants for services I cannot provide. When I do this, I need to tell them things about you and your conditions. I will get back their findings and opinions, and those will go into your records here. If you receive treatment in the future from other professionals, I can also share your PHI with them. These are

some examples so that you can see how I use and disclose your PHI for treatment.

For payment. I may use your information to bill you, your insurance, or others, so I can be paid for the treatments I provide to you. I may contact your insurance company to find out exactly what your insurance covers. I may have to tell them about your diagnoses, what treatments you have received, and the changes I expect in your conditions. I will need to tell them about when we met, your progress, and other similar things. Currently I am not billing insurance, but these guideline will go into effect at such time as I do.

For health care operations. Using or disclosing your PHI for health care operations that goes beyond my care and your payment. For example, I may use your PHI to see where I can make improvements in the care and services I provide. I may be required to supply some information to some government health agencies, so they can study disorders and treatment and make plans for services that are needed. If I do, your name and personal information will be removed from what I send.

b. Other uses and disclosures in health care

Appointment reminders. I may use and disclose your PHI to reschedule or remind you of appointments for treatment or other care. If you want me to call or write to you only at your home or your work, or you prefer some other way to reach you, I usually can arrange that. Just tell me by indicating your preference on the signed consent form.

Treatment alternatives. I may use and disclose your PHI to tell you about or recommend possible treatments or alternatives that may be of help to you.

Other benefits and services. I may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Research. I may use or share your PHI to do research to improve treatments—for example, comparing two treatments for the same disorder, to see which works better or faster or costs less. In all cases, your name, address, and other personal information will be removed from the information given to researchers. If they need to know who you are, I will discuss the research project with you, and I will not send any information unless you sign a special authorization form.

Business associates. I hire other businesses to do some jobs for me. In the law, they are called our “business associates.” Examples include a copy service to make copies of your health records, and a billing service to figure out, print, and mail our bills. These business associates need to receive some of your PHI to do their jobs properly. To protect your privacy, they have agreed in their contract with me to safeguard your information.

2. Uses and disclosures that require your authorization

If I want to use your information for any purpose besides those described above, I need your permission on an **authorization form**. I don't expect to need this very often. If you do allow me to use or disclose your PHI, you can cancel that permission in writing at any time. I would then stop using or disclosing your information for that purpose. Of course, I cannot take back any information I have already disclosed or used with your permission.

3. Uses and disclosures that don't require your consent or authorization

The law lets me use and disclose some of your PHI without your consent or authorization in some cases. Here are some examples of when I might do this.

a. When required by law

There are some federal, state, or local laws that require me to disclose PHI:

- I have to report suspected child / elder neglect/abuse.
- If you are involved in a lawsuit or legal proceeding, and I receive a subpoena, discovery request, or other lawful process, I may have to release some of your PHI. I will only do so after trying to tell you about the request, consulting your lawyer, or trying to get a court order to protect the information they requested.
- I have to disclose some information to the government agencies that check on me to see that I am obeying the privacy laws.

b. For law enforcement purposes

I may release medical information if asked to do so by a law enforcement official to investigate a crime or criminal.

c. For public health activities

I may disclose some of your PHI to agencies that investigate diseases or injuries.

d. Relating to decedents

I may disclose PHI to coroners, medical examiners, or funeral directors, and to organizations relating to organ, eye, or tissue donations or transplants.

e. For specific government functions

I may disclose PHI of military personnel and veterans to government benefit programs relating to eligibility and enrollment. I may disclose your PHI to workers' compensation and disability programs, to correctional facilities if you are an inmate, or to other government agencies for national security reasons.

f. To prevent a serious threat to health or safety

If I come to believe that there is a serious threat to your health or safety, or that of another person or the public, I can disclose some of your PHI. I will only do this to persons who can prevent the danger.

4. Uses and disclosures where you have an opportunity to object

I can share some information about you with your family or close others. I will only share information with those involved in your care and anyone else you choose, such as close friends or clergy. I will ask you which persons you want me to tell, and what information you want me to tell them, about your condition or treatment. You can tell me what you want, and I will honor your wishes as long as it is not against the law.

If it is an emergency, and so I cannot ask if you disagree, I can share information if I believe that it is what you would have wanted and if I believe it will help you if I do share it. If I do share information, in an emergency, I will tell you as soon as I can. If you don't approve I will stop, as long as it is not against the law.

5. An accounting of disclosures I have made

When I disclose your PHI, I may keep some records of whom I sent it to, when I sent it, and what I sent. You can get an accounting (a list) of many of these disclosures.

E. Your rights concerning your health information

- 1) You can ask me to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask me to call you at home, and not at work, to schedule or cancel an appointment. I will try my best to do as you ask.
- 2) You have the right to ask me to limit what I tell people involved in your care or with payment for your care, such as family members and friends. I don't have to agree to your request, but if we do agree, I will honor it except when it is against the law, or in an emergency, or when the information is necessary to treat you.
- 3) You have the right to look at the health information I have about you, such as your medical and billing records. You can get a copy of these records, but I may charge you. Contact me to arrange how to see your records.
- 4) If you believe that the information in your records is incorrect or missing something important, you can ask me to make additions to your records to correct the situation. You have to make this request in writing and send it to me. You must also tell me the reasons you want to make the changes.
- 5) You have the right to a copy of this notice. If I change this notice, I will post the new one in my office, and you can always get a copy from my website at www.nwmedicalhypnosis.com.
- 6) You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with me and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way.
- 7) You may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. I will be happy to discuss these situations with you now or as they arise.

F. If you have questions or problems

If you need more information or have questions about the privacy practices described above, please ask me. If you have a problem with how your PHI has been handled, or if you believe your privacy rights have been violated, contact me. As stated above, you have the right to file a complaint with me and with the Secretary of the U.S. Department of Health and Human Services. I promise that I will not in any way limit your care here or take any actions against you if you complain. If you have any questions or problems about this notice or my health information privacy policies, please contact me by phone at 360-513-9567 or by e-mail at debnesbittarnp@gmail.com.

The effective date of this notice is December 12, 2010.