OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first session will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation in the first session. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-minute appointment per week (or other agreed upon frequency) at a time we agree on. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 1 business day's advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. **If you cancel without 1 business day's notice, or do not show, you will be charged a $75 fee. All future appointments will be cancelled, and you will be unable to schedule another appointment until this fee is paid. If you are ill, please cancel your appointment as soon as you are aware that you are ill to prevent contagion. If you do not, we reserve the right to send you home and you will be charged a late cancellation fee . Reminder calls/texts/emails will be made as a courtesy. However, you will be held responsible for appointments whether or not you receive a reminder call.**

PROFESSIONAL FEES

My hourly fee is $125. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than **5** minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you request a letter or report, my standard fee **begins** at $80. If the letters require more work than is customary, the fees will increase accordingly. An estimate will be provided to you in advance, however we reserve the right to contact you to revise the estimate should the previous estimate prove

inadequate. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. [Because of the difficulty of legal involvement, I charge $425 for the first hour, then $200 per hour thereafter for preparation and attendance at any legal proceeding.] You should understand that I am not a forensic psychologist, nor am I expert in legal testimony, therefore I encourage you to NOT subpoena my testimony. And, there is no guarantee that my involvement with any legal proceeding will result in a favorable outcome.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless you have primary insurance coverage which requires another arrangement. **We do not file secondary insurance claims.** If you have secondary insurance you would like to file, we will be happy to provide you with information to complete your claim. Payment schedules for other professional services will be agreed upon when they are requested.

Dr. Turnbull utilizes an electronic medical records & billing service (Therapyappointment.com) for all clients who wish to utilize their insurance. Insurance companies now require electronic billing for reimbursement. If you do not wish to participate in electronic billing, you will be required to pay Dr. Turnbull directly for services & we will provide you the necessary information to be reimbursed by your insurance company directly. Therapyappointment.com also allows clients to directly schedule & cancel appointments, update insurance information, update personal information such as address or telephone, pay any outstanding balance, & send confidential messages directly to Dr. Turnbull. However, in order to utilize the system you must select a user name & password. You will be asked to include this choice on the form below, & after that information is entered into the system by Dr. Turnbull or her staff you may elect to change that information.

We accept payment in the form of cash, check, and credit card. For all credit card payments, beginning 02/18/2013 Dr. Turnbull will attach a $0.21 surcharge to every debit card transaction, and a 3% surcharge to every credit card transaction. This surcharge is imposed solely as a reimbursement of fees charged to Dr. Turnbull by Visa, Discover, & MasterCard for the convenience of using a credit card to pay for services. This surcharge is not a fee (or a tip) for any professional services provided. Thus, the surcharge is not covered by health insurance, nor is it considered to be a portion of a health insurance co-pay. For all checks written with insufficient funds, you will be expected to pay the returned check fee from Dr. Turnbull's bank, which is currently $25. No appointments will be scheduled until the returned check fee is paid with cash or credit card. If you write more than 2 checks that are returned for insufficient funds, you will be required to pay with cash or credit card for all future transactions.

This office does not allow clients to maintain an outstanding balance. You will not be scheduled for further appointments if you have an outstanding balance. If your account has not been paid for more than 30 days, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. [If such legal action is necessary, the costs of filing suit will be included in the claim.] In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. Again, we do not file secondary insurance claims.

We ask that you contact your insurance company to verify benefits prior to your first appointment. Also, you should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. [Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.]

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

CONTACTING ME

I am most often **not** immediately available by telephone. While I am usually in my office between 8:30 AM and 6:30 PM, I probably **will not** answer the phone when I am with a patient. I do have staff who will answer general questions regarding billing and appointments from 9:00 AM-4:00 PM. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. I am **not** available via email contact.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any time spent in preparing information requests, records release & copies. Most records requested to be released to other providers will require a **prepayment** of $25.

MINORS

If you are a divorced parent, or guardian of a child for whom you are seeking treatment, I require proof (i.e., copies of custody agreement) that you have the legal ability to consent for treatment *prior to treatment.*

According to Texas Department of State Health Services, Texas Family Code Chapter 32.003, a person as young as 16 years may provide informed consent for psychological treatment (i.e., seeking treatment for substance abuse, living financially & physically independent of parents, is unmarried & pregnant & seeking treatment for issues related to pregnancy, is on active duty with the U. S. armed forces, or is an unmarried parent with custody of their child & treatment is for the child.) Otherwise, if you are under eighteen years of age, please be aware that the law requires your parents consent for treatment and may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. For a fee, I may also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

CONFIDENTIALITY

Please be aware that all PUBLIC areas of this office are monitored by firewall-protected cameras to enhance the safety and security of clients, staff, and property, while protecting individuals' right to privacy. The security camera installation consists of dedicated cameras providing real-time surveillance through a central monitoring facility located on premises. Video data is recorded and stored digitally on digital video recorders equipped with onboard hard drive storage. The recorded data is confidential to H.E.B. Behavioral Medicine staff, and is secure. Both recorders and data are housed in a limited-access, controlled area. Recordings shall be kept for approximately 30 days, unless required as part of an ongoing investigation of criminal activity. For investigations initiated by law enforcement agencies, recorded data will be made available to law enforcement upon presentation of a valid court order establishing probable cause to review the data. Any such review will be with the knowledge and approval of the doctors and therapists on staff. In all other respects, recorded data will be accorded the same level of confidentiality and protection provided by Texas State Law and HIPAA Regulations.

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person, disabled person, or patient in a mental health facility is being abused, I must file a report with the appropriate state agency (even if a report has already been filed.)

If I believe that a patient is threatening serious bodily harm to another (including HIV infection and possible transmission), I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her and/or to contact family members or others who can help provide protection.

Other possible exceptions to confidentiality include: subpoenaed records for criminal prosecutions, child custody cases, and suits in which the mental health of a party is in issue; fee disputes between the therapist and the client; and in a negligence suit or licensing board/insurance company complaint brought by the client against the therapist.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Signed:_____ Date:_____
(All patients sign here. If you are signing for a minor, you signature is your assertion that you have the legal capacity to consent to mental health services as dictated by law and/or custody decree.)

Notice of Privacy Practices:

I have received a copy of HIPPA Notice of Privacy Practices.

Signed:_____ Date:_____

NEW PATIENT INFORMATION

Name:_____ Date:_____

SS#:_____ DOB:_____ Sex:___ Marital Status:_____

Home Address:_____ City:_____ Zip:_____

Home:_____ Cell:_____ Email:_____

Therapyappointment.com User Name:_____ Password:_____

I prefer to be reminded of appointments by:_____
(indicate the number/email/text where you would like us to place reminder calls)

Cell Phone Carrier: Alltel AT&T Boost Mobil Nextel Sprint SunCom T-Mobile Verizon VoiceStream Virgin Mobile Other:_____

Employer:_____ Address:_____

Who referred you to this office?_____

Emergency Contact:_____ Relationship:_____

Emergency Contact Telephone #:_____

INSURANCE INFORMATION

Name of responsible party:_____ Relationship:_____

Address and phone of responsible party:_____

_____

Name of policy holder:_____ Employer:_____

SS#:_____ DOB:_____ Sex:_____

Insurance Company:_____

ID#:_____ Group #:_____ Policy #:_____

PATIENT HISTORY

Reason for today's visit:_____

Current Psychiatric Medications:_____
Prescribed by (Dr. & telephone):_____

Past Psychiatric Medications:_____

All Other Current Medications:_____
Prescribed by (Dr. & telephone):_____

Approximate date of last medical checkup:_____done for:_____illness___routine___work

Mental Health Treatment:_____
_____
_____

Drug Use History (type, frequency, and last use, including nicotine, caffeine and alcohol):_____
_____
_____

Family mental health/substance abuse history:_____
_____

Current/past legal problems:_____
_____

Education:_____High School____College_____Graduate School_____Other_____

Employment history and current job status:_____
_____
_____

Current Living Situation: _____Parents_____Alone_____Partner_____Other

Developmental problems or learning disability_____
_____
Behavioral Problems:_____
_____
Academic Problems:_____
_____
Medication Allergies:_____

	Current	***Past***
Headaches	_____	_____
Heart Problems	_____	_____
Blood Pressure Problems	_____	_____
Digestive/Intestinal Problems	_____	_____
Kidney Problems	_____	_____
Thyroid Problems	_____	_____
Head Injury	_____	_____
Seizures	_____	_____
Eating Disorder	_____	_____
Pregnancy	_____	_____
Abnormal Menses	_____	_____
Other:_____	_____	_____

H. E. B. Behavioral Medicine
Credit Card Authorization Form

Card Holder Information		
Card Holder Name:		
Address:		
City:	State:	Zip:
Telephone:	Alt. Telephone:	
Billing Address (if different from above):		
City:	State:	Zip:

Payment Authorization

Card Type: ☐Visa ☐Mastercard ☐Discover ☐American Express

Card Number:_____ Exp. Date:_____

Card Identification Number:_____
(This is the 3 digits on the back of your card)

I wish to authorize ongoing payments for sessions or late cancellations from H. E. B. Behavioral Medicine using this credit card authorization form. I further authorize H. E. B. Behavioral Medicine to maintain my card information on file. I agree that I will pay for these sessions or late cancellations and indemnify and hold H. E. B. Behavioral Medicine harmless against any liability pursuant to this authorization. I understand that my signature on this form will serve as authorized signature on the credit card charge slip. This authorization will remain in effect until such time when a written request to cease charges is received.

H. E. B. Behavioral Medicine will process all charges using a secure bank card service. Charges will be processed to the above stated account 1 to 5 business days after the session date or late cancellation.

CONFIDENTIAL

_____ _____ _____
Printed Name Signature Date

305 Miron Dr, Southlake, TX 76092 * 817.571.2899 * 817.571.9879 (fax)

Dana Turnbull, Ph.D.

H. E. B. Behavioral Medicine

305 Miron Drive, Southlake, TX 76092

Phone: 817.571.2899, 817.329.3866 / Fax: 817.571.9879

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)
NOTICE OF PRIVACY PRACTICES

Effective April 1, 2003

Mental health therapy falls under the category of medical treatment. This notice describes how medical information about you may be used and disclosed and how you may gain access to this information. Please review the following information:

I. It is a treatment provider's legal duty to safeguard your Protected Health Information (PHI). By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice. Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office and on my website www.newsolutionscounseling.org. This policy went into effect April 15, 2003.

II. How I will use and disclose your PHI:

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures:

A) Primary Uses and Disclosures of Protected Health Information (Consent Not Required) I may use and disclose your PHI without your consent for the following reasons:

1. For treatment/coordination of care. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care.
2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.
3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you, such as to an insurance company or business associates, such as billing companies, claims processing companies, and others that process health care claims to collect fees for services rendered to you.
4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (such as unconscious or severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.
5. Business Associates: I may contract with individuals and entities to perform various functions on your behalf or to provide certain types of services. To perform these functions or to provide the services, such Business Associates will receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, I may disclose your PHI to a Business Associate to administer claims or to provide service support, utilization management, or subrogation. Examples of business associates would include your insurance company, consulting professionals, the law firm and CPA who complete required reports to the state, and the individual who completes billing and secretarial functions.
6. Other Covered Entities: I may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, I may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and I may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that I may disclose or share your PHI with other insurance carriers in order to coordinate benefits if you or your family members have coverage through another carrier.

III. Potential Impact of State Law:

The HIPAA Privacy Regulations generally do not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which I will be required to operate. For example, where such laws have been enacted, I will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

IV. Other Possible Uses and Disclosures of Protected Health Information (Consent Not Required):

The following is a description of other possible ways in which I may, and am permitted to, use and/or disclose your PHI without your consent:

1. Required by Law: I may use or disclose your PHI to the extent that other laws require the use or disclosure such as state, federal, local law, judicial board, law enforcement, or government agencies. When used in this Notice, “required by law” is defined as it is in

the HIPAA Privacy Rule. For example, I may disclose your PHI when required by national security laws or public health disclosure laws, a search warrant, or pursuant to the Texas Health and Safety Codes. This includes disclosing information in the interest of National Security. This also includes subpoenas for court testimony and an arbitrator who compels disclosure.
2. Public Health Activities: I may use or disclose your PHI for public health activities that are permitted or required by law. For example, I may use or disclose information for the purpose of preventing or controlling disease, injury, or disability. I also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.
3. Secretary of the US Department of Health and Human Services, Texas Board of Professional Examiners (or other licensing agency) and all Certifying Agencies: I may disclose your PHI if the licensing or certifying boards of your therapist's credentials or the US Department of Health and Human Services is investigation or determining my compliance with the HIPAA Privacy Rule.
4. Health Oversight Activities: I may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (1) the health care system; (2) government benefit programs; (3) other government regulatory programs; and (4) compliance with civil rights laws.
5. Abuse or Neglect: I may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence as is mandated by the Texas Child Abuse and Reporting Law. Additionally, as required by law, I may disclose your PHI to a governmental entity authorized to receive such information if I believe that you have been a victim of abuse, neglect, or domestic violence.
6. Legal Proceedings: I may disclose your PHI: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once I have met all administrative requirements of the HIPAA Privacy Rule.
7. Law Enforcement: Under certain conditions, I also may disclose your PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person, or (3) it is necessary to provide evidence of a crime that occurred on our premises.
8. Research: For example, if data is compiled for a research project. However, the information would be used to compile data, information that identifies you such as your name and address or date of birth will be withheld.
9. To Prevent a Serious Threat to Health or Safety: Consistent with applicable federal and state laws, I may disclose your PHI if I believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. I also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.
10. Military Activity and National Security, Protective Services: Under certain conditions, I may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, I may disclose, in certain circumstances, your information to the foreign military authority. I also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.
11. Workers' Compensation or Disability: I may disclose your PHI to comply with Workers' Compensation laws, requests for mental health disability, and other similar programs that provide benefits for work-related injuries or mental health illnesses.
12. Others Involved in Your Health Care: Using my best judgment, I may make your PHI known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. I may release information to parents or guardians, if allowed by law. I also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to disclosures of your PHI to a family member or close friend, then, using my professional judgment, I may determine whether the disclosure is in your best interest.

V. Uses and Disclosures of Which You Have the Opportunity to Object:

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.
2. Other Uses and Disclosures of Your Protected Health Information: Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide me with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that I already have used.
3. An appointed representative: I will disclose your PHI to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. Even if you designate a personal representative, the HIPAA Privacy Rule permits me to elect not to treat the person as your personal representative if I have a reasonable belief that: (a) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (b) treating such person as your personal representative could endanger you; or (c) I determine, in the exercise of my professional judgment, that it is not in your best interest to treat the person as your personal representative.
4. Disclosures to You: I am required to disclose to you most of your PHI in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. I am also required to provide, upon your request, an accounting of most disclosures of your PHI that are for reasons other than treatment, payment, and health care operations and are not disclosed through a signed authorization.

VI. What Rights You Have Regarding Your PHI:

__ Right to Inspect and Copy - You have the right to inspect and copy your PHI that is contained in a "designated record set." Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set. To inspect and copy your PHI that is contained in a designated record set, you must complete the form entitled "Request for Health Information." This form is available from your therapist. You will receive a response from me within 30 days of my receiving your written request. You will be charged a reasonable fee if you request a copy of your records. We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information,

you may request that the denial be reviewed. To request a review, you must contact me at the number/address provided in this Notice. A licensed health care professional chosen by me will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, my denial will not be able to be reviewed. If this event occurs, I will inform you in my denial that the decision is not able to be reviewed.

__ The Right to Request Limits on Uses and Disclosures of Your PHI - You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

__ The Right to Choose How I Send Your PHI to You - It is your right to ask that your PHI be sent to you at an alternate address or by an alternate method. You are required to complete the form "Request for Specific Mode of Communication" available from your therapist. I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.

__ The Right to Get a List of the Disclosures I Have Made - You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

__ The Right to Amend Your PHI - If you believe that your PHI is incorrect or incomplete, you may request that I amend my information by completing the form entitled "Request for Amendment of Health Information." This form is from your therapist. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

__ The Right to Get This Notice by Email - You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

VII. Complaints: You may file a complaint if you believe that we have violated your privacy rights by contacting:

Dana Turnbull, Ph.D.
Privacy Officer
305 Miron Dr
Southlake, TX 76092
(817) 571-2899 (817) 329-3866

You may also send a written complaint to:

The US Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Complaints filed with the US Department must be made within 180 days of the time you became aware of the problem, be in writing, contain the name of the entity against with the complaint is lodged, and describe the relevant problems. You will not be penalized or retaliated against in any way for filing a complaint. [9/26/09]

Dana Turnbull, Ph.D.
Clinical Psychology & Behavioral Medicine
305 Miron Drive
Southlake, TX 76092
(817) 571-2899
(817) 571-9879 (fax)

Healthcare Coordination Form

To:_____ Date:_____

RE:_____ Phone:_____

DOB:_____ Fax:_____

I am currently seeing the above patient for:_____Individual Therapy _____Family Therapy _____Nutrition Counseling_____Couples Therapy _____Pain Management _____Other_____

The patient's Axis I diagnosis is:_____Major Depressive DO _____Bipolar DO _____Anxiety DO _____Adjustment DO _____Eating DO _____Substance Abuse DO _____Other_____

I have requested the patient see you for: _____Psychotropic Medication Evaluation _____Med Management _____Continued Med Management _____R/O Physical Causes of Psychiatric SX _____Physical Exam _____Other_____

Other Concerns:___Potential harm to self/others _____Noncompliance _____Medication Side Effects _____Psychotic SX _____Information Only _____Other_____

Comments:

_____
_____
_____
_____
_____
_____
_____

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize the release of the above medical information to the above listed physician(s). I understand that the release of this information is to permit my healthcare providers to coordinate my care. This authorization becomes effective on the date signed and expires six months later, unless revoked by me previously in writing. Additional information may be provided to the above recipient only with signed consent from me. I further understand that I have the right to receive a copy of this authorization upon my request.

_____

Signature of Patient (18 or older), Parent, or Legal Guardian Date

RELEASE OF INFORMATION AUTHORIZATION

H. E. B. BEHAVIORAL MEDICINE
DANA TURNBULL, PH.D
305 Miron Drive Southlake, TX 76092
(817) 571-2899 / (817) 571-9879 fax

I hereby authorize Dr. Dana Turnbull (address listed above) to release & exchange information

to/ with _____
(name of party who holds your information)

located at _____
(address of party who holds your information)

with telephone/fax numbers:_____

To release the following specified information regarding the treatment dates of: _____
(month/year)

on patient: _____
(Patient Name)

Date of Birth: _____ Social Security #:_____

I request the following information be released/exchanged:

___ Psychiatric evaluation
___ Office Notes
___ Entire Record
___ Other

I understand these records include drug/alcohol/mental health related information. A photocopy of this authorization should be considered as valid as the original. This consent is subject to revocation by the undersigned. Absent that event, it shall expire six (6) months from the date signed .

_____ _____
Patient signature if 16 or older (date)

_____ _____
Legal guardian signature if required Witness signature