Welcome to PsyCare, Inc.

(completed by patient or parent/legal guardian)

Patient Name_____ **File#:**_____

Welcome! We are happy to have you or your family member as a patient and will do everything within our professional capacity to make the treatment as productive as possible.

The specifics of the treatment goals and the steps to achieve these goals will be discussed at the first appointment. Your participation and understanding of the treatment goals are essential for the best benefit of therapy. If you ever have any questions about the nature of the treatment or anything else about the care, please do not hesitate to ask.

CONFIDENTIALITY and AUTHORIZATION TO RELEASE INFORMATION

It is understood that all information between patient and psychiatrist/therapist is held strictly confidential, and the psychiatrist/therapist will not release any information about therapy unless permitted by law or:

1. It is agreed upon in writing and complies with State Laws,
2. The patient presents an imminent danger to self,
3. The patient presents an imminent danger to others,
4. Child/elder abuse/neglect is suspected,
5. As necessary for continuity of care,
6. If a judge determines that our discussions are not confidential, a judge may request specific information,
7. As requested by a court appointed attorney for a child involved in court proceedings.

It is understood that in cases #2, #3 and #4, the psychiatrist/therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken. If I participate in group counseling, I agree not to discuss any details of the group outside of the counseling sessions. PsyCare follows the 'minimum necessary" rule for release.

PATIENT CONSENT TO RELEASE OF INFORMATION

I consent to information release about my case (or my child's case) with the referral source and other co-treating health care providers and facilities for the purposes of treatment, payment and Health Care Operations. I further consent to the release of information to my health plan for claims, certification/case management/quality improvement and other health plan purposes.

GENERAL CONSENT FOR TREATMENT

I further authorize and request that my psychiatrist/therapist carry out psychological examinations, treatment, and/or diagnostic procedures that now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

GENERAL CONSENT FOR TREATMENT CHILD (If patient is a child or dependent of beneficiary)

On the patient's behalf, I (the legal Guardian or Legal Representative) authorize PsyCare to deliver mental health services to the patient. I understand that all policies stated on this page apply to the patient. **I accept that the child's records are confidential and that by law, I cannot have access to the child's records if such access would be detrimental to the child.**

CONSENT TO TREATMENT SIGNATURE

_____ _____ _____ _____

Patient/Legal Representative Signature Date **2nd Parent Custody Signature** Date

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION WITHIN THE PSYCARE SYSTEM

I authorize that PsyCare providers may disclose any information**, including Drug and Alcohol Abuse and HIV status**, regarding my (my child's) treatment for purposes of Continuity of Care within the PsyCare system only. Such a disclosure is only for the purposes of continuity of care within PsyCare, including between providers and to permit our various departments to aid in provision of services.

_____ _____ _____ _____

Patient/Legal Representative Signature Date **2nd Parent Custody Signature** Date

Welcome to PsyCare, Inc.

Patient Name_____ **File#:**_____

FINANCIAL TERMS

I understand that PsyCare is performing a courtesy for me by billing my insurance company and it is ultimately my responsibility to know my insurance benefits and coverage. Upon verification of health plan/insurance coverage and policy limits, my insurance carrier will be billed for me and my provider will be paid directly by the carrier. PsyCare will make every effort to assist me in getting my claims paid correctly, however, PsyCare may need to contact me to have me help resolve claim issues with my insurance company. **I will be responsible for any applicable deductibles and co-payments at the time of service. I agree to make these payments at each appointment.** I understand that I will incur a charge of $10 for any balance not paid and for every time PsyCare generates a bill for me. I do have the option of paying cash, due at time of service, and then billing my insurance company directly for reimbursement. I understand that if I am not eligible at the time services are rendered, I am responsible for payment, even if the determination is made after services are rendered. I understand the charge for a bounced check is $20.

THERE WILL BE A SERVICE CHARGE OF $10 FOR EACH STATEMENT GENERATED.

APPEALS AND GRIEVANCES

I acknowledge my right to request reconsideration in the case that outpatient care (number of visits) are denied certification (Appeal). I understand that I would request an Appeal through my Provider and that I risk nothing in exercising this right. I also acknowledge that I may submit a grievance to the Provider, Clinical Director, or Quality Management Team at any time to register a complaint about any aspect of my care. When appropriate, individual cases will be reviewed by the Medical Director. If I am not satisfied with the response I receive, I may submit the Grievance to my insurance directly.

EMERGENCY PROCEDURES

If you need to contact your provider, leave a message according to the instructions on the phone service and your call will be returned. If an emergency situation arises, follow the emergency procedures and/or inform the answering service that your call is an emergency. Please do this for true emergencies only. There may be a charge for telephone consultations that require 10 minutes or longer.

SATISFACTION SURVEYS, ASSESSMENTS

To maintain and enhance the quality of the services we provide, you will occasionally be asked to provide us with your input regarding the care you receive. We value your opinions and assure you all information is kept confidential. When you are asked to provide your thoughts during the course of your treatment, please provide us with your honest evaluation of the services you have received. We carefully consider all responses and make changes, when necessary, to provide enhanced services.

ZERO TOLERANCE FOR THREATENING/VIOLENT BEHAVIOR

PsyCare has a zero-tolerance policy for any threatening and/or violent behavior. If I exhibit any threatening and/or violent behavior, my care will be immediately terminated. _____ ***Patient's Initials***

CANCELLED/MISSED APPOINTMENTS & REQUEST FOR RELEASE OF RECORDS

In the event of a "No Show" or failure to give **a full 24-hour notice** of a cancellation, a **$75 charge will be assessed to all late cancellations and missed appointments.** If I sign to request my records to be released, there will be a $0.25/page fee for release of records (government agency requests are excluded), in addition to a $14 fee to retrieve older charts from storage where applicable. Charges will not exceed $30 total.

_____ / _____ ***Patient's Initials/2nd Custody Parent Initial***

I have received a copy of the "Patients Privacy Notice" and Patient's/Client's "Rights and Responsibilities".

_____ / _____ ***Patient's Initials/2nd Custody Parent Initial***

_____ _____

Patient/Legal Representative **Name**-*Please Print* Date

_____

Patient/Legal Representative **Signature**

_____ _____

If applicable, 2nd Parent Custody **Signature** and ***Please Print Name*** Date

_____ _____

Provider Signature and License # Date

Welcome to PsyCare, Inc.

(completed by patient or parent/legal guardian)

Patient Name_____ **File#:**_____

Advisement & Acknowledgement of Initial Consultation ONLY

NOT an Agreement to Accept and Provide Clinical Care

You have been scheduled to see a PsyCare clinician for an initial consultation, and if clinically indicated, an additional follow-up visit.

The purpose of these initial visits is to provide you with an evaluation of your condition and to assess if it is within the scope of experience and expertise of the clinician to provide you with further treatment.

Should the clinician find your condition to be beyond their particular clinical ability, then you will be duly informed and recommended to call your insurance for additional referrals.

However if your clinician has determined that your condition is within the scope of their expertise, you will be asked to schedule appointments for further treatment.

At any point of this evaluation process, should your symptoms worsen or you feel at risk, you will be directed to call 911 or go to the nearest emergency room.

Advisement & Acknowledgment of Provider Status

ALL PHYSICIANS have independent practices with PsyCare and are not employees.

YOUR THERAPIST _____ is an **employee** <OR> **independent contractor** (*circle one*) at PsyCare.

CURES Notice

Beginning July 1, 2016, California law requires all licensed prescribers to register for access to the CURES system. As part of your care, your provider may review the CURES website; a centralized resource for medical professionals to verify current and previously prescribed controlled substances. The use of CURES website is one of the components of the standard of care established by The Medical Board of California, to assist physicians in determining the best treatment course for their patients.

By signing below, I have read and acknowledge the above Advisement & Acknowledgement of Initial Consultation ONLY, Advisement & Acknowledgment of Provider Status & CURES notice.

_____ _____

Patient/Legal Representative **Name**-*Please Print* Date

_____

Patient/Legal Representative **Signature**

_____ _____

If applicable, 2nd Parent Custody **Signature** and ***Please Print Name*** Date

Welcome to PsyCare, Inc.

(completed by patient or parent/legal guardian)

Patient Name_____ **File#:**_____

Advisement Regarding Secondary Insurance

Please be aware you are required by law to inform PsyCare of any and all insurances you have. In addition, you are not able to choose which insurance you would prefer to use as your primary. If the patient is an adult and has their own coverage, this must be used as primary. If the patient is a minor, the primary insurance is of the parent whose birthday occurs first in the year. Failure to disclose any insurances, or failure to incorrectly indicate which insurance is your primary, could result in additional bills for which you will be responsible.

By signing below, I have read and acknowledge the above Advisement Regarding Secondary Insurance.

_____ _____

Patient/Legal Representative **Name**-*Please Print* Date

_____

Patient/Legal Representative **Signature**

_____ _____

If applicable, 2nd Parent Custody **Signature** and ***Please Print Name*** Date

PSYCARE THERAPIST (PHD, LCSW, MFT) PAPERWORK
INITIAL EVALUATION AND DEVELOPMENT OF TREATMENT GOALS

Patient/Client Name: _____ Patient File #: _____

DOB: _____ Sex: _____ Marital Status: _____ Primary Care Physician: _____

Occupation: _____ Education: _____ Others living in the home: _____

Emergency Contact: _____ Phone#: _____

PRESENTING PROBLEMS:

Please describe the reasons for seeking counseling (include date/month the problem started):

_____

HISTORY OF PRESENT ILLNESS

Completed by Patient/Client

Please indicate how the following symptoms/problems/complaints are effecting you:(Leave blank if no effect)

1)Little 2)Some
3)Much 4)Significant

___Eating habits/Appetite: eating more; eating less; weight change_____; binge; purge.
___Sleep: Trouble falling asleep; Trouble staying asleep; Trouble waking up; Average # hours sleep_____ #Naps_____
___Decreased energy/Fatigue
___Sexual functioning
___Loss of interest in activities
___Tearfulness
___Hopelessness/Helplessness
___Decreased attention span
___Inattentive/Distractible
___Memory: Long term; short term
___Difficulty planning ahead
___Opposition
___Anger outbursts
___Impulse control; difficulty controlling physical behavior or hyperactive
___Mood changes
___Anxious/Nervous
___Worry/Fear
___Stealing
___Lying
___Truancy
___Fire setting

Start Time: _____ End Time: _____

CLINICAL PRESENTATION

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

TARGET SYMPTOMS	**MEASURABLE GOALS /TF***
1. _____	_____
_____	_____
2. _____	_____
_____	_____
3. _____	_____
_____	_____
4. _____	_____

*TF = Time Frame (<3 mo, <6 mo, <12 mo, Ongoing)

Patient/Legal Rep. Signature Provider Signature/License# Date

PSYCARE THERAPIST (PHD, LCSW, MFT) PAPERWORK
INITIAL EVALUATION AND DEVELOPMENT OF TREATMENT GOALS

Patient/Client Name: _____ Patient File #:_____

HISTORY OF PRESENT ILLNESS continued

Completed by Patient/Client	Completed by Provider Target Symptoms	MEASURABLE GOALS /TF*
__ Police/Probation involvement __ Spending sprees __ Rapid Heartbeat __ Phobia __ Sweating __ Trouble Breathing __ Flashbacks of traumatic event __ Nightmares __ Racing thoughts __ Hearing Voices __ Seeing things that are not there	5. _____ _____ 6. _____ _____ 7. _____ _____	

Substance Use

Completed by Patient/Client	Completed by Provider Comments	Completed by Provider Goals and Interventions
Coffee (#____cups/daily) Cigarettes (#____ per day) Alcohol (#____ drinks/weekly) Date last drank: _____ **Street drugs:** Type:_____ Amount:_____ Frequency:_____ Date last used:_____ **Prescription Drugs:** Type:_____ Amount:_____ Frequency:_____ Date last used:_____ Describe impact of substance Abuse use on your life:_____ _____ _____ Past treatment for substance use: _____ _____ Family history of substance use: _____	Describe onset and duration; blackouts; withdrawal; attempts to stop; legal problems; DUI; work problems; relationship problems; hospitalizations, treatment.	Recommendations: Does the patient/client need further evaluation? YES NO Referral for CD Tx needed?: YES NO Relapse prevention; education.

*TF = Time Frame (<3 mo, <6 mo, <12 mo, Ongoing)

Patient/Legal Rep. Signature Provider Signature/License# Date

PSYCARE THERAPIST (PHD, LCSW, MFT) PAPERWORK
INITIAL EVALUATION AND DEVELOPMENT OF TREATMENT GOALS

Patient/Client Name: _____ Patient File #: _____

Psychosocial History/Functioning

Completed by Patient/Client	**CLINICAL PRESENTATION & LEVEL OF FUNCTIONING**
Rate how the problems/symptoms/ complaints are impacting areas of **FUNCTIONING:** **1) Mild 2) Moderate 3) Severe** __ Marriage/Relationship __ Work/School __ Family __ Friendships __ Financial situation __ Physical health __ Social interests __ Leisure activities __ Clubs/Group memberships __ Legal __ Housing __ Attending to daily living activities (i.e. shower, grooming, self care, etc.) __ Spirituality __ Current stressors Other _____	_____ _____ _____ _____ _____ _____

TARGET SYMPTOMS	**MEASURABLE GOALS/TF***
1.	
2.	
3.	
4.	

WHAT DO YOU SEE AS STRENGTHS: _____

WHAT DO YOU SEE AS WEAKNESSES: _____

GOALS FOR TREATMENT: _____

GOALS AND EXPECTATIONS OF SIGNIFICANT OTHERS: _____

_____

MOTIVATION FOR TREATMENT: _____

WHAT CULTURAL EXPERIENCES DO YOU FEEL WOULD BE HELPFUL IN YOUR TREATMENT: _____

_____
Patient/Legal Rep. Signature Provider Signature/License# Date

PSYCARE THERAPIST (PHD, LCSW, MFT) PAPERWORK
INITIAL EVALUATION AND DEVELOPMENT OF TREATMENT GOALS

Patient/Client Name: _____ Patient File #: _____

Past Treatment History

Completed by Patient/Client	Completed by Provider Comments
Psychiatric or psychological treatment of any kind before? YES___ NO___ If **Yes**, What type of care was received? Inpatient___ Outpatient___ Both___ When was the treatment?_____ Where was the treatment?_____ _____ How long was the treatment?_____ Name(s) of therapist or doctor:_____ _____ Were medications prescribed at that time? YES___ NO___ Not applicable___ If **Yes**, what was prescribed (include dosages if known)?_____ Family history of psychiatric treatment: _____ Family members currently in psychiatric treatment: _____	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Patient/Legal Representative Must Complete the following Medical History

MEDICAL HISTORY: _____

ALLERGIES: _____

Current Medications: (Dosage, frequency, and prescribing M.D.) _____

_____

HISTORY OF INFECTIOUS DISEASES: (PANDAS, encephalitis, Lyme Disease, meningitis, GABHS) None Reported ☐

_____

DATE OF LAST PHYSICAL: _____

Are you currently taking any medication for PAIN MANAGEMENT? YES NO

If **YES,** what medication? _____

Prescribing Pain Medication M.D. _____

Over the Counter Medications, Herbal Medicines, Supplements: _____

_____

FEMALE LIFE CYCLE HISTORY: Current # pregnancy? _____ Are you planning for pregnancy? _____

If **YES**, when? _____ When was your last menstrual period? _____

Are you currently using any form of birth control? If **YES**, what? _____

Other information the provider should know (i.e. family medical history): _____

_____

_____

Patient/Legal Rep. Signature Provider Signature/License# Date

CONSUMER NOTICE OF RIGHTS AND RESPONSIBILITIES

DIGNITY AND RESPECT

You have the right to be treated with considerations, dignity, and respect-and the responsibility-to respect the rights, property, and environment of all physicians and other health care professionals, employees and other patients.

- You have the right to access your own treatment records and have the privacy and the confidentiality of those records maintained.
- You are also entitled to exercise these rights regardless of gender, age, sexual orientation, marital status or culture, or economic, educational or religious background.

KNOWLEDGE AND INFORMATION

You have the right to receive information about the organization's services and practitioner, clinical guidelines, and members' rights and responsibilities.

You have the right-and the responsibility-to know about and understand your health care and your coverage, including:

- Participating with your physician and other healthcare professionals in decision-making regarding your treatment planning. Having participated and agreed to a treatment plan, you have a responsibility to follow the treatment plan or advise your provider otherwise.
- The names and titles of all health care professionals involved in your treatment.
- Your clinical condition and health status.
- Any services and procedures involved in your recommended course of treatment.
- Any continuing health care requirements following your discharge from a provider's office, hospital, or treatment program.
- How your health plan operates-as stated in your Policy and/or Certificate.
- The medications prescribed for you-what they are for, how to take them properly and possible side effects.

ELIGIBLE EMPLOYEE ACCOUNTABILITY/AUTONOMY

As a partner in your own health care, you have the right to refuse treatment providing you accept responsibility and the consequences of such a decision-and the right to refuse to participate in any medical research projects.

You have a responsibility to participate, to the degree possible, in understanding your behavioral health problems and developing mutually agreed upon treatment goals. You also have the responsibility to:

- Identify you and insurance coverage or changes in coverage when receiving behavioral health services.
- Provide your current provider with previous treatment records, if requested, as well as provide accurate and complete medical information to any other health care professionals involved in the course of your treatment.
- Be on time for all appointments and to notify your provider's office as far in advance as possible if you need to cancel or reschedule an appointment.
- Receive all non-emergent or urgent care through your assigned behavioral health provider and obtain pre-authorization of service from Managed Care Company, if applicable.
- Notify your behavioral health plan within 48 hours or as soon as possible-if you are hospitalized or receive emergency care.
- Pay all required co-payments and deductibles at the time you receive behavioral health care services.

FILING A COMPLAINT

Please fill out our complaint form, available in all offices, if you have a complaint. The complaint will be forwarded to the Quality Management Department for follow-up. You will be contacted with the resolution within 5 business days. You may also contact the customer service department of your health plan. If you are not satisfied with the plans' resolution, you may appeal the decision. The California Department of Corporations is responsible for regulating health care service plans. The department has a toll-free number (800) 400-0815; to receive complaints regarding health plans. If you have a grievance against the health plan, you should contact the plan and use the plans grievance process. If you need the department's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by the plan, you may call the departments' toll-free number.

RIGHT TO LANGUAGE ASSISTANCE

Under California Law, an individual seeking mental health services who has limited English proficiency has the right to request language assistance and interpretation, which will be provided by the health plan. Notify the office staff or provider and we will help you receive these services.

PSYCARE, INC.

Coordination of Care

With Primary Care Physician and Healthcare Providers

PATIENT SECTION TO COMPLETE

Patient Name:_____ Patient Birth Date:_____

Patient Address, City, State, Zip:_____

Name of Patient's Primary Care Physician (PCP):_____

PCP's Address, City, State, Zip:_____

PCP Phone #:_____ PCP Fax #:_____

I **AUTHORIZE** the disclosure of confidential mental health information between my Mental Health Provider and my Primary Care Physician/Healthcare Provider. I give permission to disclose diagnoses and treatment information about my child or me for the purposes of Continuity of Care. **I understand and expressly authorize the release of information related to any Substance Abuse or HIV status.** This authorization is valid unless revoked by me in writing at any time.

Patient/Legal Guardian Signature:_____ ***Date:***_____

****

BEHAVIORAL HEALTH PRACTIONER SECTION

☐ **Initial Psychiatric Evaluation**
☐ **Treatment Update**

Dear _____,

I saw your patient for an initial evaluation on _____.

Current diagnoses are _____ _____
(For Psychiatrists) I have prescribed the following medication and dosages: _____

_____

Outpatient care is appropriate at this time and the initial treatment will consist of the following:
Medication Management ☐ Individual Psychotherapy ☐ Family/Conjoint therapy ☐ CD IOP ☐
Inpatient care/partial hospitalization is necessary and patient has been referred to_____
Other Clinical:_____

_____

If you need additional information, please contact me at PsyCare, (858) 279-1223 ext. _____

Provider Signature: _____ Date:_____

Printed Provider Name: _____ License #: _____

****

<OR> (PLEASE SIGN BELOW IF YOU ARE REFUSING TO RELEASE INFORMATION)

I **REFUSE** to authorize the release/exchange of any behavioral health and medical information between my behavioral health provider and my primary care physician/healthcare provider to promote the continuity of my behavioral health care and my general medical care.

Patient/Legal Guardian Signature:_____ ***Date:***_____

PsyCare Child/Adolescent Development Form

(For patients under 18 years old)

Patient/Client Name: _____ **Patient File #:** _____

Date: _____ DOB: _____ Current Grade: _____

Pregnancy and Birth: Full term: □Yes □ No C-Section: □Yes □ No

Complications or problems during pregnancy and/or birth: _____

_____

Developmental Milestones: (ages) sat-up _____ crawled _____ walked _____ talked _____ toilet training _____

Describe delays or complications in any of the above areas: _____

_____

Describe any illnesses and/or surgeries or other medical conditions: _____

_____

Traumas: □ Yes □ No If Yes, describe: _____

Day Care: □ Yes □ No If Yes, Where/When: _____

Comments: _____

Preschool: □ Yes □ No If Yes, Where/When: _____

Comments: _____

1st-5th Grade: Where: _____ Grades: _____

Describe behavior: _____

Type of classes (i.e. special ed., GATE, etc.) _____

Comments: _____

6th-8th Grade: Where: _____ Grades: _____

Describe behavior: _____

Type of classes (i.e. special ed., GATE, etc.) _____

Comments: _____

_____

Provider Signature Provider License# Date

PsyCare Child/Adolescent Development Form

(For patients under 18 years old)

Patient/Client Name: _____ **Patient File #:** _____

9th Grade and up: Current Grade: _____

Describe behavior: _____

Type of classes (i.e. special ed., GATE, etc.) _____

Comments: _____

Social Development: Clubs: _____

Sports: _____

Hobbies: _____

Family Life: (i.e. Include age and dates: adopted, parents divorced, significant losses/deaths, blended family, moves, etc.):

_____

_____

_____

Describe Family Relationships: _____

_____

Describe Peer Relationships: _____

_____

Describe Problems: _____

_____

_____

Form completed by: _____ Relationship to child: _____

_____

Provider Signature Provider License# Date

PsyCare Associates, Inc.

a professional medical corporation

PsyCare's Notice of Privacy Practices

Ann Mellusi, LCSW, HIPAA Compliance Officer (858) 279-1223 ext. 306

Original Effective Date:1/1/2010; Revised 1/1/2014

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

PsyCare understands the importance of privacy and are committed to maintaining the confidentiality of your medical information. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. Please carefully read our "Welcome to PsyCare" packet that outlines more details.

We strive to always take reasonable precautions to protect your privacy. When appropriate, we provide the minimum necessary information to only those we feel are in need of your health care information. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate our medical corporation.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this notice, please contact our HIPAA Compliance Officer listed above.

A. HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION:

PsyCare may use or share your information for reasons directly connected to your treatment or for payment pertaining to your treatment. Our practice collects health information regarding your treatment and stores it in a chart. This is your medical record. This medical record is the property of our practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following reasons:

- **Treatment:** We use medical information about you to provide your medical care. We will share information with doctors, hospitals, and others in order to provide the care you need.

- **Payment:** We use and disclose medical information about you to obtain payment for the services we have provided. In addition, we may forward bills to other health plans or organizations for payment.

- **Health Care Operations:** We may use the information about your medical care to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detections and compliance programs and business planning and management.

B. OTHER USES FOR YOUR HEALTH INFORMATION:

- We may receive an order from a court to give out your health information. We also may give information to a court, investigator and/or lawyer under certain circumstances.
- You or your doctor and other health care providers may appeal decisions made about claims for your health care. Your information may be used to make these appeal decisions.
- We may share your health information with the federal government, as requested, in relation to privacy rules.

- We may disclose health information, when necessary, to prevent a serious threat to your health/safety or the health/safety of another person, or the public. Such disclosure would be made only to someone able to help prevent the threat.
- We may use and disclose medical information to contact and remind you about future appointments. We may leave this information on your answering machine or with the individual answering the phone at the number you have provided.

C. WHEN WE MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION:

Except as described in this Notice of Privacy Practices, PsyCare will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you authorize PsyCare to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

D. YOUR PRIVACY RIGHTS

- You have the right to ask us not to use or share your personal health care information in the ways described in this notice. We will abide by your request, unless we must disclose the information for treatment or legal reasons.
- You have the right to ask us to contact you in a specific way or at a specific location, e.g. only in writing or at a different address. We will comply with all reasonable requests when necessary to protect your safety.
- You have the right to inspect and copy your health information, with limited exceptions. You must submit a written request to PsyCare, Inc., 4550 Kearny Villa Road, Ste. 116, San Diego, CA 92123, detailing what information you want access to, and if you would like to inspect or copy your records. There may be a fee for the cost of copying and mailing records. We may keep you from seeing certain parts of your records for reasons allowed by law. If we deny your request to access a child's records or an incapacitated adult you are representing it is because we believe allowing access would likely cause substantial harm to the patient, you have a right to appeal this decision.
- You have the right to ask that information in your records be amended if it not correct or complete. We may refuse your request if: (a) the information is not created or kept by PsyCare, or (b) we believe it is correct and complete. If we do not make the changes as requested by you, you may ask that we review our decision. You also may send a statement as to why you disagree with our records and this statement will be kept with your records.
- When we share your health information, you have the right to request a list of what information was shared, with whom it was shared, when it was shared, and for what reasons. This list will NOT include when we share information with you relating to your treatment, payment, medical group operation, or requests as required by law.
- You have the right to be informed of a breach within 60 days of the date a breach has been discovered. We will notify you of any breach by first class mail by including the following information in the notification: Circumstances of the breach, date of the breach, date of the discovery, type of information involved, the steps taken to mitigate harm and to protect against future breaches and how you can obtain additional information about the breach.
- You have the right to request an additional copy of PsyCare's Notice of Privacy Practices Policy.

E. HOW TO CONTACT US TO USE YOUR RIGHTS:

If you would like to use any of the privacy rights explained in this notice, please call or write us at: PsyCare, Inc. HIPAA Compliance Officer, 4550 Kearny Villa Road, Ste. 116, San Diego, CA 92123, or phone (858) 279-1223 or fax (858) 467-7161.

F. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES:

We reserve the right to amend this Notice of Privacy Practices at any time in the future. We will keep a current copy posted in our reception area, a copy is avail. by request each appointment and we will post the current notice on our website (www.psycare.org).

G. COMPLAINTS:

If you believe that we have not protected your privacy and you wish to file a complaint/grievance, please call or write to PsyCare, Inc., HIPAA Compliance Officer, 4550 Kearny Villa Road, Ste. 116, San Diego, CA 92123, or phone (858) 279-1223 or fax (858) 467-7161. For additional information you may call the U.S. Department of Health and Human Services at (619) 515-4243 or the Office of Civil Rights at (877) 696-6775.
A formal complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.