PATH TO EMPOWERMENT

PathToEmpowermentTherapy.com

Ananda Jatel, LMSW
Ananda@PathToEmpowermentTherapy.com

ADULT INTAKE FORM

GENERAL INFORMATION

Please provide the following information and answer the questions. Information you provide here is protected as confidential information. Please fill out this form prior to your first session.

Name:_____ Today's Date:_____

Your age: _____ Date of Birth (DOB):_____

Address:_____

_____

Spouse or Partner's Name (if applicable): _____

Home phone:_____May I leave a message? Yes No

Cell phone:_____May I leave a message? Yes No

Work phone:_____May I leave a message? Yes No

Email: _____May I email you? Yes No

What is the main reason you're seeking help? (Please include how long you've had these symptoms or problems): _____

_____

_____

_____

What are your goals for therapy?_____

_____

_____

HEALTH & MENTAL HEALTH INFORMATION

Do you currently have any medical problems? _____

_____

_____

Have you ever been treated for any of the following? If so please circle and describe:
Head injury, strokes, seizures, fainting, loss of consciousness, neurological conditions (Multiple sclerosis, Parkinson's), cancer, headaches, diabetes/kidney, allergies, chronic fatigue, high fevers, surgeries, any other conditions:

_____

_____

Have you previously/currently seen a therapist or psychiatrist?

Have you ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

Please list current prescription medications with dosage (psychiatric and general health):

Do you drink alcohol or use recreational drugs? If so, what kind and how often? _____

Who is your primary care physician? _____

How many times a week do you exercise? _____

What kinds of foods do you regularly eat? _____

CURRENT FAMILY, SOCIAL SUPPORTS, OCCUPATION & LIFE INTERESTS/ACTIVITIES

Intimate Relationships & Social Supports

Are you currently married? Yes No How long?_____

Are you currently partnered/in a romantic relationship? Yes No How long? _____

Do you have any concerns about your current marital or romantic relationship that you would like to discuss? If so what are they?

Are you currently separated or divorced? Yes No How long? _____

Please describe your social relationships. Do you have friends and/or extended family? Go out for fun? Socialize? Whom can you turn to for emotional and other forms of support?

Employment and/or Current Educational Situation

Are you currently employed? Yes No Are you currently a student? Yes No

Please describe your current work or academic situation: _____

_____

_____

Do you enjoy your work/school? Is there anything stressful about it? _____

_____

Interests/Activities/Spirituality

What are some of your interests & activities? _____

_____

_____

Do you consider yourself spiritual or religious? Yes No

Is so, describe your spirituality/faith and you level of participation in a faith-based group (if applicable) :_____

_____

_____

How much are <u>each</u> of the following areas currently a problem for you? (Please Circle)

	Not at all	**A little**	**Somewhat**	**Considerable**	**Intense**
	1	**2**	**3**	**4**	**5**
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Family Conflicts	1	2	3	4	5
Marital Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
Job/School	1	2	3	4	5

What do you consider to be your strengths?_____

_____

What do you consider to be your areas of needed growth? _____

_____

Client Signature:_____Date:_____

Consent to Services/Rights Acknowledgment

I hereby request and consent to services for myself/dependent which includes therapy, diagnostic assessment, case coordination, consultation, and other treatment/services recommended and considered necessary. I understand that developing a treatment plan with my therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by my therapist.

I agree that traditional (face-to-face) and virtual (online) therapy involves the use of electronic communications (video, telephone, texts, emails, appointment reminders, etc.) with Path to Empowerment mental health providers to connect with individuals and may include interactive video and audio communications. When applicable, virtual therapy includes the practice of psychological and behavioral health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatment I receive at this clinic. I understand that if payments for the services I receive at this clinic are not rendered, then the clinic may stop my treatment.

I am aware that I may stop my treatment with my therapist at any time. The only thing I will still be responsible for is paying for the services I have already received.

By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based, in-person psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

I have been informed that any information regarding services at Path to Empowerment are subject to release only by my informed and written consent or by subpoena and/or court order. I have also been informed that patient identifying information about me may be exchanged between office staff and other designated/contracted providers for continuity of care purposes.

I authorize this clinic to release any medical information necessary to process claims for the services provided. I authorize payment of governmental/medical benefits to this clinic for services provided. I understand that I remain responsible for any and all charges not met by my insurance company.

Client Signature:_____ Date:_____

Telehealth/Virtual Therapy

The guidelines that govern traditional therapy also apply to virtual therapy. Path to Empowerment is not responsible for additional risks related to virtual therapy. I understand that there are risks and consequences from virtual therapy, including, but not limited to, the possibility, despite reasonable efforts on the part of Path to Empowerment, that: the transmission of my personal information could be disrupted or distorted by technical failures, could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Clients are not allowed to make an audio or video recording of any portion of the virtual session. Client understands that if counselor believes they would be better served by another form of intervention (e.g., face-to-face services), they will be referred to a mental health professional that can provide such services in the catchment area. Client understands that there are potential risks and benefits associated with any form of psychotherapy. If virtual services are not available due to an unplanned equipment or service malfunction, sessions will occur via telephone or an alternative method. Client agrees to maintain an environment of confidentiality in location they choose to participate in virtual sessions. Fees for virtual sessions must be paid in advance. Fees will apply to no-show and late cancel appointments. I have read and understand the information provided and consent to any associated risks for virtual therapy.

Client Signature:_____Date: _____

Agreement to pay for services

I agree to pay for all the services that I receive in full. When utilizing insurance I understand that I am responsible for all charges that are incurred, which includes sessions that are denied by my insurance provider. I am also aware that it is my responsibility to pay all co-insurance and co-payment amounts for all services provided. These rates are established by your insurance provider and are non negotiable. I am aware that if I do not attend a scheduled appointment, arrive more than 15 minutes late or cancel without providing 24 hours notice I am responsible for paying for the session.

The following rates differ according to the insurance provider being utilized, however these rates provide a basis for client responsibility when denial is received from your insurance provider.

Rates:
$225 for intake appointments or the amount negotiated by your health care provider.
$150 for family therapy or the amount negotiated by your health care provider.
$165 for individual therapy or the amount negotiated by your health care provider.

$150 will be charged per hour for paperwork completed outside of sessions (court, disability, social security, coordination of care etc)

It is important to verify your insurance benefits before engaging in services. Insurance providers my pay for a portion of the cost or the entirety of the services depending on your benefits. Please reach out to us if you have any questions.

__Please initial here if you DO NOT plan on utilizing insurance provider.

__Please initial here if you plan on utilizing an insurance provider.

By signing below I acknowledge the financial responsibilities outlines above.

Client Signature:_____Date:_____

Income Based Payments

This option is typically for those who do not have insurance or prefer not to bill your insurance provider.

Sliding Scale Rates: Can be paid by cash, check or credit card (subject to a 3% service fee).

$80 per session for a household income of 20,000 or less
$90 per session for a household income of 20,001 to 30,000
$100 per session for a household income of 30,001 to 40,000
$110 per session for a household income of 40,001 to 50,000
$120 per session for a household income of 50,001 to 70,000
$130 per session for a household income of 70,00 and above

(household income consists of the combined revenue of all members who reside in the home)

Client Signature:_____ Date:_____

Cancellation Policy

We look forward to working with you and value our time with our clients. Sessions typically run for 45-60 minutes, with some exceptions for 75 minute sessions. It is important for us to be able to maintain a healthy rhythm for ourselves and our clients, we ask that you are on time for all scheduled sessions. If you arrive 15 or more minutes late to your scheduled session it will be rescheduled and you will be subject to the cost of the session. Insurance companies will not pay for partial or unattended sessions, the client is fully responsible for these costs. The cost incurred is $130 for the missed session. We require 24 hours notice for cancellation, no fees will be assessed for cancellations with adequate notice provided. We request that cancellations for Monday appointments be provided on Thursday to provide our therapists adequate notice. If patterns of cancellations or no shows develop the therapist reserves the right to end the therapeutic relationship or develop an attendance plan that accommodates all parties involved.

My signature below indicates that I acknowledge and agree to the cancellation policy.

Signature:_____ Date:_____

Path to Empowerment, PLLC

Provider Name:_____

PATIENT INFORMATION

Last Name_____First_____MI_____

Street Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Email Address_____

Communication Preferences: **Ok to leave phone message?** Yes ☐ No ☐ **Ok to text message?** Yes ☐ No ☑ **Ok to email** Yes☐ No ☐

Gender as enrolled with insurance company_____Female_____Male Language Preference _____

Date of Birth_____Age_____ Preferred Pronouns _____

Race: ___Asian____American/Alaskan Indian_____Black/African American_____Hawaiian_____Other/Unk_____White____Declined

Ethnicity:_____Hispanic / Latino_____Non Hispanic /Non Latino_____Declined

GUARANTOR INFORMATION

LEGAL GUARDIAN, OR WHOMEVER BRINGS IN MINOR CHILD OR INCAPACITATED ADULT, MUST COMPLETE THIS SECTION

Last Name_____First_____MI_____

Street Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Email Address_____

Communication Preferences: **Ok to leave phone message?** Yes ☐ No ☐ **Ok to text message?** Yes ☐ No ☐ **Ok to email** Yes ☐ No ☐

Date of Birth_____Age_____ Language Preference _____

Release of Information to Third Party Payors/Agents & Authorization and Assignment of Benefits Agreement for Payment of Services:
I authorize my provider to disclose portions for the clinical record on the client named below to my insurance company and/or its contracted managed care/utilization review company for the purpose of reimbursement of services rendered at this facility. Such disclosure may include review and release of copies of psychiatric/psychological and/or substance abuse diagnosis, history & physical examinations, intake assessment, treatment plan, progress notes, testing results, discharge summary and any other information or records necessary for the discharge of the legal contractual obligations of the insurance company.

I hereby release my provider and its' officers, agents, employee and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the insurance company and/or its contracted managed care/utilization review company.

By signing this release, I acknowledge the following:

1. I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance hereon.
2. I agree that this authorization will be valid during the pendency of the claim.
3. I further authorize that payment be made to my provider of service on my behalf.
4. I understand that I am financially responsible for all charges not covered by insurance and/or those stated to be patient responsibility by the third party payor.
5. I understand that any expense that is incurred by my provider associated with collecting the balance on my account, such as collection fees and/or attorney's fee will be my responsibility to pay.

Patient OR Guarantor Signature (if patient is a minor or incapacitated adult)_____Date_____

Medicare Authorization and Assignment of Benefits: (MEDICARE PATIENTS ONLY)
I request that payment of authorized Medicare Benefits be made either to me or on my behalf for any services furnished by or in the office of my provider of service. I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefit of related services.

Signature_____Date_____

COPY OF INSURANCE CARD MUST BE INCLUDED

Path to Empowerment, PLLC

Medicaid Beneficiary Financial Acknowledgment

Path to Empowerment, PLLC is committed to providing quality services to Medicaid Beneficiaries and <u>will not bill you for the following circumstances:</u>

- Medicaid-covered services. Our office will inform you before the service is provided if Medicaid does not cover the service.
- Medicaid-covered services for which the provider has been denied payment because of improper billing, failure to obtain PA, or the claim is over one year old and has never been billed to Medicaid, etc.
- The difference between the provider's charge and the Medicaid payment for a service.
- Missed appointments.
- Copying of medical records for the purpose of supplying them to another health care provider**.**

Path to Empowerment, PLLC is however entitled to payment from you directly for the following and <u>you will be billed for these amounts:</u>

- Copayments and Co-Insurance, Deductibles and Cost Sharing
- Services that are rendered for non-covered services (i.e. more than one visit in the same day)
- Amounts that are paid to you by another insurance
- You will be held financially responsible if your Health Plan does not authorize the service and your provider informs you of this.
- You have primary insurance coverage and you do not follow the network rules.
- You have primary insurance coverage and you do not disclose this information and/or provide proof of coverage.
- When you elect not to use your Medicaid policy and you want to be billed directly for services.

<u>We will not deny services to a beneficiary who is unable to pay their copay at the time of service</u>. However, you will be billed for this debt and after 90 days of sending you monthly statements and non-payment, your care may be terminated and transferred to a provider of your choosing. We will provide you with 30 days' notice of the care termination and we will provide one copy of your medical record at no charge to you.

_____ _____

Patient/Beneficiary Name Guarantor Signature and Date

_____

Provider Signature and Date

Path to Empowerment

Telehealth Informed Consent – Behavioral Health Services

Patient Name: _____

Date of Birth: _____

Date of Consent: _____

1. Purpose and Nature of Telehealth

You are being offered behavioral health services through telehealth, which allows you to receive care from your provider using real-time audio and/or video technology. This form explains your rights, the risks and benefits of telehealth, and important compliance requirements, including the federal in-person visit requirement established by the Centers for Medicare & Medicaid Services (CMS).

2. In-Person Visit Requirement (Effective October 1, 2025)

Beginning October 1, 2025, federal regulations (per CMS) require that patients receiving mental health services via telehealth must have at least one in-person visit with their behavioral health provider as follows:

- Initial Requirement: An in-person visit must occur within 6 months prior to your first telehealth behavioral health appointment.
- Ongoing Requirement: At least one in-person visit every 12 months must occur thereafter, as long as you continue to receive telehealth services.
- Exceptions: If your provider determines that an in-person visit would create hardship or risk that outweighs the clinical benefit, they may document this rationale in your medical record.

Failure to meet these in-person requirements may affect your ability to continue telehealth services or may result in services not being covered by your insurance plan.

3. Benefits of Telehealth

• Increased access to care
• Continuity of treatment
• Improved scheduling flexibility
• Reduced travel time

4. Risks and Limitations

• Technology issues may disrupt or delay sessions
• Confidentiality may be limited by your environment
• Telehealth may not be suitable for all clinical needs

5. Confidentiality and Privacy

Your telehealth sessions are protected by HIPAA and applicable privacy laws. You are responsible for ensuring privacy at your location during sessions.

6. Technology Requirements

You will need a secure internet connection and a device with video and audio capability. Your provider will use a HIPAA-compliant platform.

7. Patient Rights

You have the right to withdraw consent, refuse telehealth, and ask questions about your care at any time.

8. Emergency and Crisis Procedures

Telehealth is not appropriate for emergencies. In crisis, contact 911 or the National Suicide and Crisis Lifeline at 988.

Provide Current Location Address During Telehealth: _____

Provide Emergency Contact Name & Phone: _____

9. Consent and Acknowledgment

By signing below, I acknowledge that I understand the information above, consent to telehealth services, and agree to comply with the federal in-person visit requirement.

Patient / Legal Guardian Signature: _____ Date: _____

Addendum Behavior Health Consent

Name of Client: _____ Date of Birth: _____

Mobile Application:

- □ It may mean that my private health information may be transmitted from my practitioner's mobile device to my own or from my device to that of my practitioner via an "application" (abbreviated as "app").
- □ *I understand that other methods of behavioral health care may be available to me, and that I may choose one or more of these at any time. My behavioral health care provider has explained the alternative to my satisfaction.*

Equipment:

□ I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer's computer or network. I am aware that any information I enter into an employer's computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.

Identification:

□ I understand that I will be informed of the identities of all parties present during the consultation or who have access to my personal health information and of the purpose for such individuals to have such access.

Telebehavioral Health Process:

□ My behavior health care practitioner has explained how the telebehavioral health consultation(s) is performed and how it will be used for my treatment. My behavioral practitioner has also explained how the consultation(s) will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.

Electronic Presence:

□ In brief, I understand that my practitioner will not be physically in my presence. Instead, we will see and hear each other electronically, or that other information such as information I enter into an app will be transmitted electronically to and from myself and my practitioner.

Limitations:

- □ Regardless of the sophistication of today's technology, some information my practitioner would ordinarily get in in-person consultation may not be available in teleconsultation. I understand that such missing information could in some situations make it more difficult for my practitioner to understand my problems and to provide the most effective intervention(s). Further, this missing information is of greatest potential detriment in the event of significant emotional crisis.

Risks:

- □ I understand that telebehavioral health is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, possibly including some that are not yet recognized.
- □ Among the risks that are presently recognized is the possibility that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the consultation(s), and that the information will be intercepted by an unauthorized person or persons.
- □ *In rare instances, security protocols could fail, causing a breach of privacy of personal health information.*

Release of Information:

 I authorize the release of any information pertaining to me determined by my practitioner, or by my insurance carrier to be relevant to the consultation(s) or processing of *insurance claims*, including but not limited to my name, Social Security number, birth date, diagnosis, treatment plan and other clinical or medical record information.

Discontinuing Care:

- I understand that at any time, the consultation(s) can be discontinued either by me or by my practitioner.
- I further understand that I do not have to answer any question that I feel is inappropriate or whose answer I do not wish persons present to hear; that any refusal to participate in the consultation(s) or use of technology will not affect my continued treatment and that no action will be taken against me.
- I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly.
- Were that to happen, my telehealth-based treatment might be less successful than it otherwise would be, or it could fail entirely.

Limits of Confidentiality:

 I also understand that, under the law, and regardless of what form of communication I use in working with my practitioner, my practitioner may be required to report to the authorities information if I am assessed to be of imminent risk of danger to myself or others.

Alternatives:

 The alternatives to the consultation(s) have been explained to me, including their risks and benefits, as well as the risks and benefits of doing without treatment. I understand that I can still pursue in-person consultations. I understand that the telebehavioral health consultation(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the telebehavioral consultation's effectiveness.

Records:

- I understand that copy(ies)/recording(s) of telehealth consultation(s) are not saved and are therefore not available to me.

Contact Information:

- I have received a copy of my practitioner's contact information, including his or her name, telephone number, business address, mailing address, and e-mail address.
- I am aware that my practitioner may contact the proper authorities and/or my designated, local contact person in case of an emergency.

Emergency Care:

 I acknowledge that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person; Telehealth IS NOT an appropriate vehicle for care in this situation; and I am not to seek a telebehavioral consultation. Instead, I agree to seek care immediately through a local crisis service, health care practitioner, at the nearest hospital emergency department or by calling 911.

 These are the names and telephone numbers of my local emergency contacts Including local physician; crisis hotline; trusted family, or friend.

Name	Relationship	Telephone
Name	Relationship	Telephone
Name	Relationship	Telephone
Name	Relationship	Telephone

Release of Liability:

 I unconditionally release and discharge _____and its affiliates from any liability in connection with my participation in the remote consultation(s) / therapy sessions.

Final Agreement:

 I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers.

 With this knowledge, I voluntarily consent to participate in the telebehavioral consultation(s) , and including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

 As a legal guardian, with this knowledge, I voluntarily consent to the participation of my MINOR CHILD and other family members (as clinically indicated and agreed upon) in telebehavioral consultation(s) and including and not limited to any care, treatment, and services deemed necessary and advisable, under terms described herein.

Client Printed Name

_____

Signature of Client or Legal Guardian **Date** _____

_____

Printed Name of Practitioner/Witness

_____

Signature of Practitioner/Witness **Date** _____

_____

Path to Empowerment, PLLC

ACKNOWLEDGMENT OF SELF–PAY STATUS PATIENT RESPONSIBILITY

Dear Patient,

You are being provided this letter of acknowledgement because you have requested that your therapist visit today be coded as “self-pay”.

You have requested that this service be coded as self-pay because (**initial one**):

_____ You have no health insurance.

_____ You have health insurance, but you do not want your insurance billed & instead want to pay out of pocket. You are also agreeing not to seek reimbursement from your insurance company for these services.

_____ Other (please explain): _____

We want you to know what to expect so that you can make an informed decision. In order to accomplish this, by signing below you agree to the following:

- All fees for the self-pay service must be paid on the date of service.

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions. I confirm that I am the patient, or the patient’s duly authorized representative.

Patient or Legal Representative Signature _____

Date _____ Time _____

If signed by someone other than the patient, please specify relationship to the patient:

_____

TELEHEALTH ABN

A. Notifier: Path to Empowerment, PLLC

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** Services below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** Services below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Outpatient Psychotherapy Services performed via Telehealth	Diagnosis may not meet medical necessity OR Telehealth Guidelines may not allow	$_____ per visit

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** Services listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the **D.** Services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** Services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** Services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

HIPAA Notice: Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. When changes are made, the new notice will be available upon request, either in our office, and/or on our website.

SUBSTANCE USE DISORDER TREATMENT

42 CFR Part 2 Addendum

Section 1: Patient Information

Patient Name:	_____
Date of Birth:	_____
Date Completed:	_____

Section 2: Substance Use Assessment

Primary Substance(s) of Concern:

- ☐ Alcohol
- ☐ Cannabis/Marijuana
- ☐ Cocaine/Crack
- ☐ Methamphetamine
- ☐ Opioids (heroin, fentanyl, prescription painkillers)
- ☐ Benzodiazepines (Xanax, Valium, Klonopin)
- ☐ Stimulants (Adderall, Ritalin)
- ☐ Other: _____

Current Use Status:

- ☐ Active use (used within past 30 days)
- ☐ Early remission (1-12 months abstinent)
- ☐ Sustained remission (12+ months abstinent)
- ☐ In recovery/on MAT (Medication Assisted Treatment)

Medication for Opioid Use Disorder (if applicable):

- ☐ Currently on MAT: ☐ Methadone ☐ Buprenorphine/Suboxone ☐ Naltrexone/Vivitrol

  Prescribing Provider: _____

  Dosage: _____

Previous SUD Treatment:

- ☐ Never treated for SUD before
- ☐ Previous outpatient treatment
- ☐ Previous intensive outpatient (IOP)
- ☐ Previous residential/inpatient treatment
- ☐ Previous detoxification

Most recent treatment: _____

Dates: From ___/___/_____ to ___/___/_____

Section 3: Notice of Federal Confidentiality Protection

IMPORTANT: YOUR SUBSTANCE USE DISORDER RECORDS ARE PROTECTED BY FEDERAL LAW

The confidentiality of your substance use disorder patient records is protected by Federal law and regulations (42 CFR Part 2).

What this means:

- This practice cannot confirm or deny that you are receiving substance use disorder services without your written consent
- Your SUD records cannot be disclosed without your written consent, except in limited circumstances
- Your SUD records are protected even more strictly than other medical records under HIPAA

Limited Exceptions (disclosure allowed without consent):

- Medical emergency - to medical personnel to address the emergency
- Court order - only if court order meets strict Part 2 requirements (subpoena alone is not enough)
- Child abuse reporting - as required by state law
- Audit/evaluation - for qualified personnel conducting audits with strict confidentiality safeguards

Your Rights:

- You control who can see your SUD records
- You can give permission for specific people/organizations to receive your records
- You can revoke (cancel) your permission at any time in writing
- These protections apply even after you leave treatment

Patient Signature:	_____
Date:	_____

Section 4: Consent for Use & Disclosure of SUD Records

I, _____ (Patient Name), Date of Birth: ___/___/_____

voluntarily consent to the use and disclosure of my substance use disorder treatment records as described below.

1. Program Making Disclosure

Provider/Practice Name: _____
Address: _____
Phone: _____
Provider NPI: _____

2. Who May Receive My SUD Records

I authorize disclosure of my SUD records to the following recipients for purposes of coordinating my care, billing insurance, and healthcare operations:

☐ **OPTION A: General Authorization (RECOMMENDED)**

I authorize disclosure to ALL of the following who have a treating provider relationship with me:

- All current and future healthcare providers involved in my treatment (including physicians, psychiatrists, therapists, hospitals, labs, pharmacies)
- All insurance companies/health plans responsible for payment (including Medicare, Medicaid, private insurance)
- Care coordinators and case managers

Note: This option allows seamless coordination of care without separate consent for each provider.

☐ **OPTION B: Limited Authorization**

I want to limit disclosures to ONLY the specific individuals/organizations listed below:

Name/Organization: _____ **Address:** _____ **Purpose:** _____
Name/Organization: _____ **Address:** _____ **Purpose:** _____
Name/Organization: _____ **Address:** _____ **Purpose:** _____

Note: If you choose this option, you will need separate consent for each new provider.

3. What Information May Be Disclosed

☐ Substance use disorder assessment and diagnosis

☐ Treatment plans and progress notes

☐ Attendance/participation in treatment

☐ Medication information (including medications for opioid use disorder)

☐ Drug/alcohol screening results

☐ Discharge summaries and aftercare plans

☐ All other SUD treatment records

Exclusions - I do NOT authorize disclosure of:

☐ Psychotherapy notes (if maintained separately)

☐ SUD Counseling Notes (if maintained separately)

☐ HIV/AIDS status

☐ Other: _____

4. Purpose of Disclosure

☐ Treatment - To coordinate my behavioral health and medical care across providers

☐ Payment - To bill insurance and process claims for services

☐ Health Care Operations - For quality improvement, care coordination, case management, and program administration

5. Duration of Consent

This consent is effective as of the date signed below and expires:

☐ When my treatment at this practice ends

☐ One (1) year from the date signed below, then renews annually unless I revoke

☐ On this specific date: ___/___/_____

☐ When revoked by me in writing

6. Redisclosure by Recipients

IMPORTANT - Please read carefully:

If the recipient of my records is a HIPAA covered entity (hospital, doctor, insurance company):

They may redisclose my SUD records in accordance with HIPAA Privacy Rule regulations

EXCEPTION: They CANNOT redisclose my SUD records for use in any civil, criminal, administrative, or legislative proceedings against me without my specific written consent or a valid court order

If the recipient of my records is NOT covered by HIPAA:

- They are prohibited from redisclosing my SUD records without my written consent
- Federal law restricts any further disclosure

7. My Right to Revoke (Cancel) This Consent

I understand that I have the right to revoke this consent at any time.

To revoke this consent, I must:

1. Submit a written revocation request to: [Provider/Practice Name and Address]
2. Include my name, date of birth, and signature
3. My revocation will be effective on the date it is received

Effect of revocation:

- Once revoked, no further disclosures will be made under this consent
- My revocation will NOT apply to disclosures already made before the revocation
- Revoking consent may affect my ability to continue receiving certain services (such as coordination of care with other providers or insurance billing)

8. Consequences of Not Signing

I understand that:

- My treatment is NOT conditioned on signing this consent
- I may refuse to sign this consent without penalty
- However, if I do not sign this consent:
    - My provider may be unable to coordinate my care with other healthcare providers
    - My provider may be unable to bill my insurance for services
    - I may be responsible for full payment for services
    - Communication with other providers involved in my care will be limited

9. Right to Receive a Copy

- I have the right to receive a copy of this signed consent
- I may request a copy at any time
- Each disclosure made under this consent will be accompanied by either a copy of this consent OR a clear explanation of what information can be shared

Section 5: Patient Signature - Voluntary Consent

I have read this consent (or it has been read and explained to me). I understand its contents and I voluntarily consent to the use and disclosure of my substance use disorder treatment records as described above.

I understand that I can revoke this consent at any time by submitting a written request.

Patient Signature:	_____
Date:	_____
Patient Name (Printed):	_____

If Signed by Personal Representative:

☐ I am the parent/legal guardian of a minor patient (under age 18)

☐ I am the legal guardian (guardianship documentation attached)

☐ I am the healthcare power of attorney (documentation attached)

☐ I am the personal representative of deceased patient

☐ I am court-appointed (court order attached)

Personal Rep. Signature:	_____
Date:	_____
Relationship to Patient:	_____

Provider/Staff Verification:

I verify that I reviewed this consent with the patient, answered all questions, and provided a copy of the signed consent.

Provider/Staff Signature:	_____
Date:	_____
Provider/Staff Name:	_____

Michigan LARA Information: This practice operates under Michigan law and may be subject to oversight by:
Michigan Department of Licensing and Regulatory Affairs (LARA)
Bureau of Community and Health Systems
Phone: 1-833-757-7308