



Minor Patient/Client Information

Client Name: _____ SSN: _____

Client Date of Birth: _____ Sex: Male Female

Father Name: _____ Is address same as client? Yes No

Mother Name: _____ Is address same as client? Yes No

Would you prefer the client to be referred to as a Patient or Client? Please check one: Client Patient

Client Address: _____

Phone Nos. & Email: _____

Emergency contact: _____

How did you find me? _____

Medical or mental health providers: [Please provide a list of medications taken.]

Psychiatrist _____ Last seen: _____

Primary Care Physician _____ Last seen: _____

Other _____ Last seen: _____

Counselor: _____ Last seen: _____

Insurance: (attach copy of card)

Company: _____ Policy No. _____

Group No. _____ Phone: _____

Name of Insured: _____ Insured DOB: _____

Referred by _____

I hereby authorize the release of any medical or other information necessary to process claims to my insurance company. I also authorize payment of medical benefits from my insurance company to Happy Brain Counseling, L.L.C. for services provided.

Signature of patient/client
Or

Date: _____

Guardian/Parent

Date: _____

Guardian/Parent

Date: _____

Please understand there are no exceptions to this policy.



About the Therapists
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Camille Reinhold

Email: reinhold@happy-brain.com

Office: 314-717-0190

By way of introduction, I am a Licensed Professional Counselor (LPC) with the State of Missouri. Prior to licensure, I received a graduate degree in Counseling and Family Therapy, with a focus on human development, at Saint Louis University in January 2009. In May 2011, I received an Executive Masters of International Business from Saint Louis University and am certified by the American Board of Quality Assurance and Utilization Review Physicians in Health Care Quality and Management (CHCQM).

As a counselor, I believe that you know yourself better than anyone and that you possess the skills necessary to identify problems that you would like to change and to make the necessary adjustments you believe to be important. Thus, we will collaborate to identify therapeutic goals. My job as a therapist is to help you to identify those problems by allowing you to tell your story and then to help you to alter this story in the way you choose and that works for you. This is a narrative approach to therapy. I am also influenced by emotion-focused therapy, which concentrates on identification of the emotions that generate anger, depression, and anxiety. This therapy has been well researched and is documented to create benefits with individuals and couples by using emotions and thoughts to create positive changes. I frequently work with children and adolescents and use Play Therapy to put children at ease and to create a bond of trust with them.

Kelly Locker

Email: kelly@happy-brain.com

Office: 314-502-9072

By way of introduction, I am a Licensed Professional Counselor (LPC) with the State of Missouri. Prior to licensure, I received a Masters of Education in Community Counseling from the University of Missouri St. Louis. In addition, I am a Certified Hypnotherapist, having received my certification from the Mottin & Johnson Institute of Hypnosis in 2006. Lastly, I am a Level II Reiki Practitioner, which means I can perform both hands on and distant healing. Reiki (pronounced ray-key) is a form of therapy that uses simple hands-on, no-touch, and visualization techniques, with the goal of improving the flow of life energy in a person.

As a counselor, I believe that you are the expert in your own life and that you possess the necessary skills, strengths, talents and abilities to identify problems that you would like to change. Therefore, we will work in collaboration to identify and meet therapeutic goals. My job as a therapist and hypnotherapist is to act as your guide and facilitator to help you identify those problems. Furthermore, I work as a holistic therapist, which means I believe in treating mind, body and spirit in therapy. To do this, I utilize an integrative approach. I do not believe in a one-size-fits-all kind of therapy. Some of the approaches I utilize are cognitive behavioral (CBT), solution-focused brief therapy (SFBT) and Internal Family Systems (IFS). Cognitive Behavioral Therapy is a directive approach which assumes that changing maladaptive thinking will lead to changes in affect

Please understand there are no exceptions to this policy.



About the Therapists
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and behavior. Solution-Focused Brief Therapy, as the name suggests, puts the focus on solutions rather than the problem that brought the client to therapy. SFBT also focuses on the present and future desires of the client and does not dwell in the client's past. Internal Family Systems is an integrative approach which views the mind as being made up of distinctive parts, or subpersonalities, all of which have a positive intent for the person. When dysfunction or disharmony arise, the therapist works with the client to connect with their true Self and bring the parts back into harmony.

Mary Anne Potts

Email: MaryAnne@happy-brain.com

Office: 314-626-0986

I am a Licensed Professional Counselor (LPC) with the State of Missouri. I received a graduate degree in Counseling and Family Therapy, with a focus on human development and an emphasis in research, from Saint Louis University in May 2009. Since that time, I have worked with children, adults, and families at a private counseling practice in St. Charles, and at Washington University as part of a research team exploring perinatal depression and effective therapy approaches. Currently I work as a counselor at Birthright Counseling St. Louis, where I provide individual and group counseling for women during pregnancy and postpartum.

I believe in a collaborative approach to counseling. Together we will create a plan for counseling that will allow you to attain your goals. I use a blend of solution focused and cognitive behavioral therapies, which encourage personal growth and encourage expansion of skills that work for you. I believe that relationships are instrumental to our personal happiness and often when things don't feel right, it can be beneficial to explore the relationships in our lives. I utilize the ideas of Interpersonal Therapy which believes that all aspects of our life are impacted by interpersonal changes, be they relationships, life transitions - such as becoming a parent, new job, etc., and the grieving process.

During my time as a counselor, I have participated in several local organizations such as Missouri Mental Health Counselors Association, St. Louis Counsel on Child Abuse and Neglect, and Generate Health. Most recently I have participated in trainings that focused on trauma informed care and Motivational Interviewing.

Roberta Keroševic, PLPC

Email: Roberta@happy-brain.com

Office: 515-996-5806

Roberta Keroševic is a Provisional Licensed Professional Counselor (PLPC) and graduated May 2020 with a MS in Clinical Psychology from Missouri State University. She completed an 11 month



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internship at Betty & Bobby Allison Ozarks Counseling Center in Springfield, MO. She has worked with children, adolescents, adults, and couples. She has worked with clients in dealing with lifestyle changes, goal setting, grief, emotional regulation, managing self-esteem, post-partum depression, anxiety, depression, and much more. Roberta also worked as an administrative assistant at the same center while obtaining her hours required to graduate.

Roberta is bilingual in English and Bosnian. Her therapeutic style is eclectic, meaning she does not stick to just one type of therapy and fits it to the individual or couple. This usually includes a mix of any of the following: cognitive behavioral therapy (CBT), dialectical behavioral therapy (DBT), solution-focused brief therapy (SFBT), person-centered therapy, and motivational interviewing (MI). Roberta believes that no matter what your age and where you are at in your life, change is possible!

Roberta accepts self-pay on a sliding fee scale based on household income, listed below. This scale is the PLPC rates. LPC rates can be found on page 8.

Annual Household Income	Self-Payment Amount	Check (✓)
\$100,000 or more	\$100	
\$85,000 - \$99,000	\$80	
\$70,000 - \$84,000	\$70	
\$69,000 or less	\$60	

Please understand there are no exceptions to this policy.



About the Therapists
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All Happy Brain Therapists:

We will try to return all calls within 24 hours. It is important that we are aware of any change in your address or telephone numbers to allow for my prompt care.

At the first session, we will review with you the goals and direction of therapy and parties that will be involved. It is possible that during therapy we will review our goals and readjust the parties involved in therapy, such as a move from working with a couple to working with a family. In any transition, we will review together the ethics, relationships between the parties, and emotional safety of the parties in these types of transitions, and whether the parties would be better served working with another mental health professional. When working with children, we always strongly encourage the participation of both biological parents, although there are some exceptions to this, and appreciate the support and the involvement of the entire family, including step-parents. When working with children and families, there may be times that we work with parties alone or in different dyads together, including the entire family with step-parents.

There are times that we work with multiple parties within a family individually. It is important to us that emotional safety and confidentiality, and the trust in the therapist's confidentiality, be maintained. If at any time you do not feel emotionally safe, please notify your therapist and discuss the best methods to resolve your concerns. It is important to the mental health professionals at Happy Brain that you always feel emotionally safe.

In order to ensure emotional safety for families, it is important that all parties are compliant with therapy. Therapists may terminate the therapy for non-compliance or issues above our competency. Non-compliance would include disrespect for the mental health professional or other members of the family. Disrespect could include, among other things, name calling, yelling or screaming. In some cases, the dysfunction of the family could be too severe for the private practice therapeutic setting and the therapist may refer a person or persons to more comprehensive care.

Please understand there are no exceptions to this policy.



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We strive to provide therapy that is respectful and ethical to each client, couple, or family. To that end, we are affiliated with the American Counseling Association (ACA), a professional organization with current codes of ethical conduct that we endeavor to uphold. The Code of Ethics of American Counseling Association (ACA), can be found online at <http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx> We have also chosen to evaluate ethical dilemmas using a format similar to that of R. M. Kidder (1995), who identifies three ethical principles: the greatest good for the greatest number of people, the highest sense of principle, and the Golden Rule (do to others what you want them to do to you).

In order that we may provide consistency with your current medical or mental health care, it is important that we are aware of all medical or mental health care professionals that you are currently seeing or that you have seen in the past. Most of the time, we will acquire a release from you to discuss their care provided and/or to receive a summary of care provided or their records.

It is your legal right to review or obtain a copy of your counseling chart. We would strongly urge you to not to exercise this right as the information contained would likely not be in your best interests to personally review, to share with others or to use in a legal proceeding. It is possible that reading this information could be detrimental to your therapeutic progress. In the event you would still require a copy of your chart, we will require an executed HIPAA authorization (a form that we can provide), and we will make the copy of your file available to you within the 45-day requirement. Completely separate from your counseling chart, we also keep a running journal of psychotherapy notes. Under the Code of Federal Regulations (CFR), specifically 45 CFR Section 164.524 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA; HHS, 2003) (see <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html>), patients do not have a right to see these notes. Further, third party payers may not condition payment on receiving a copy of these records, although they may request your counseling chart. Copies of psychotherapy notes would only be provided by express and explicit court order after relevance of these notes/journal entries was justified.

I have reviewed this information with the therapist, and I agree to the above terms:

Date: _____

Client/Patient: _____

Date: _____

Happy Brain Counseling, LLC

Please understand there are no exceptions to this policy.



Office Information and Policies

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Regarding Confidentiality

The privacy and confidentiality of your therapy is very important. Information shared between the client/patient and therapist remains private and is protected health information. There are exceptions, however, when this protected information must be shared with others. These exceptions include:

- 1) Insurance purposes: A diagnosis is required to justify payment. In this case, often a treatment plan is required. The treatment plan includes a statement of the problem for which you sought treatment, your psychiatric diagnosis, symptoms to justify the diagnosis, alcohol and drug use, a mental health treatment history, a list of current medications, treatment goals, progress notes, and interventions used.
- 2) Consultation: In your best interest, I will be consulting on a regular basis with other professionals about your case. All efforts will be made to keep your identity confidential.
- 3) Legal and ethical issues: Missouri state law requires all therapists to report any suspected cases of children abuse to the Division of Family Services. Further, therapists have a duty to report any suspected intent to harm yourself or others. If the therapist believes it is necessary, the potential victim, medical/psychiatric health care professionals, the police, or anyone else the therapist believes should have this information will be notified.

Regarding Fees and Payment

A full session is between 45 to 60 minutes. Some insurance is accepted and self-pay amounts are determined by the sliding scale fee on page 5. Payment in full is expected at the time of service. In case of treating minor children, the parent(s) or guardian is(are) held responsible for payment at the time of service. Outstanding account balances in excess of \$200 may cause an interruption in care, at the discretion of the therapist. Fees unpaid for more than three months will be sent to collection and attorney's fees will be payable by the client. In the event the therapist is subpoenaed for court appearance/testimony or for deposition testimony, the client agrees to pay \$150.00 per hour for preparation time, court report preparation time and travel time, and \$250.00 per hour for deposition or testimony time, with a five hour minimum required, and the client agrees to pay any expenses for travel, and the like, in full. For deposition and trial testimony, the minimum payment is required the Friday before the event, due to weekend preparation time requirements. Further, the minimum (\$1,250) is not refundable if the hearing or deposition is cancelled or rescheduled due to the therapist's schedule being cancelled and the preparation time that occurs in advance.

For IBSR, there is a one-time charge of \$200. This is not covered by insurance. If you are an existing Happy Brain client, the fee will be the same as your existing counseling services, as a courtesy.

For hypnosis, sessions are 90 minutes for a cost of \$200. This is not covered by insurance. First sessions include a free intake. If you do not decide to proceed with hypnosis, there is no cost to you. Please ask about package rates and discounted rates for existing Happy Brain clients.

There are times that we collaborate with other parties, such as legal counsel, Guardian ad Litem, physicians, teachers, and the like. For legal consultations, we charge \$150 per hour for the portions of time that we consult and for medical and school professionals we charge in accordance with the self-payment amount or insurance allowable.

Canceled or Missed Appointments

Scheduled appointments are times specifically held for the patient/client. Cancellations must be made 24-hours in advance of the appointment to avoid a fee. Please remember our goal is to allow another person on the waiting list to be scheduled for that canceled appointment. The fee for missed appointments or same day cancellations is the full cost of the session [self-pay or insurance plus co-payment amount]. Repeated failed appointments or late cancellations may result in your therapy being canceled. Please note insurance does not pay for missed appointments and it will be billed to the client.

Please understand there are no exceptions to this policy.



Office Information and Policies Page 2 of 2

Office Hours and Contact Information

To schedule or cancel an appointment, please contact us at (314) 717-0190 or your counselors direct phone line found on our website. If we are unavailable or if you are calling after hours every effort will be made to accommodate your needs within 24 hours. If you have an emergency please contact 911, and/or go to the nearest emergency room, and/or call one of the following numbers: Behavioral Health Crisis Line (314) 469-6644 or Life Crisis Services (314) 647-4357.

SELF-PAYMENT SLIDING SCALE FEE

If you are using insurance, please skip to the Attestation section below. The self-payment advantage is your mental health care will truly be confidential and not shared with your insurance company. If you are using self-payment, please choose the self-payment amount that applies to you based upon your household income, meaning the total annual income by those living in your household. Please check the box that corresponds to your household income.

Annual Household Income	Self-Payment Amount	Check (✓)
\$100,000 or more	\$165	
\$85,000 - \$99,000	\$130	
\$70,000 - \$84,000	\$100	
\$69,000 or less	\$80	

ATTESTATION

I have read and understand the above office policies and agree to these policies. I understand I am responsible for all charges, regardless of insurance coverage. I further agree to receive therapeutic services.

Date: _____ Client Signature: _____

In case of a minor client:

Date: _____ Minor: _____

Parent Name: _____ Signature: _____

Parent Name: _____ Signature: _____

I have thoroughly reviewed these office policies and informed consent with my therapist:

Date: _____ Signature: _____

Please understand there are no exceptions to this policy.



Kirkwood Oaks Office Building
12203 Big Bend Road, Suite 101
Kirkwood MO 63122
(314) 717-0190 Office
(314) 754-7275 Fax

Card Payment Authorization Form

Sign and complete this form to authorize Happy Brain Counseling L.L.C. to debit your credit/debit card listed below. By signing this form you give us permission to debit your account for the amount indicated as payment for the specified co-payment for each session and/or for the amount indicated as payment for missed or canceled appointment in accordance with your agreement with Happy Brain Counseling L.L.C..

Please complete the information below:

I _____ authorize Happy Brain Counseling, L.L.C., to charge my credit/debit card account indicated below for invoiced copayment amounts each counseling/therapy session with Happy Brain Counseling L.L.C. I further authorize Happy Brain Counseling, L.L.C. to charge my credit/debit card for copayments, self-payments and missed or same-day cancellations.

Billing Address _____

Phone# _____

City, State, Zip _____

Email _____

Account Type: Visa MasterCard Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC) _____

SIGNATURE _____

DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Please understand there are no exceptions to this policy.



HIPAA Consent Form

This document is a notice of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and prepared by Happy Brain Counseling, L.L.C., to help you understand your privacy rights. You may also review the full and complete HIPAA document prior to signing this consent. The Notice of Privacy Practices is posted in the waiting room, as legally required, and describes your privacy rights and how protected health information about you may be used by me and may be disclosed to others for the purpose of treatment, payment, health care operations, or for an appointment reminder. Signing this form will give you the right to request that I restrict how protected health information is used and disclosed for treatment, payment, health care operations, or appointment reminders. This restriction is binding.

There are circumstances where your information is used without your prior and express permission:

1. When I am required by law to involuntarily treat you;
2. For public health or safety issues;
3. As required by State, Federal, or local law; and,
4. For law enforcement.

Even in these instances, I will, if at all possible, keep you informed.

You have the right to inspect records but this does not include psychotherapy notes or information compiled in anticipation of litigation. Psychotherapy notes are defined as detailed notes recorded by a mental health professional, documenting or analyzing the contents of conversations during a private, couples, family, or group counseling session. To inspect and/or copy mental/medical health records you must submit your request in writing to me, using a valid HIPAA release of information, which form I can provide to you upon request. Upon your written and valid request for medical records, I have 45 days (RSMo. Section 191.227) to provide such records and I will charge the legally allowed fee for such copies, or a \$25.00 administration fee plus \$.15/page (RSMo. Section 191.227).

I reserve the right to change the Notice of Privacy Practices, which is also posted in my waiting area, and it is effective per the date on the top right-hand corner. Disclosure of your health information that is not covered in the Notice of Privacy Practices will not be made without your written authorization. If you provide me with written authorization to use or disclose information, you can change your mind and revoke your authorization at any time and only in writing. If you revoke your authorization, I will no longer use or disclose information about you; however, I will not be able to take back any disclosures made pursuant to your previous authorization. If you believe your privacy rights have been violated, you may report the problem to HIPAA on their website at www.HIPAA.uab.edu.

I have reviewed this HIPAA Consent Form and the attached Notice of Privacy Practices with Happy Brain Counseling, L.L.C.:

Date: _____

Client name printed: _____

Legal guardian name printed: _____

Date: _____

Happy Brain Counseling, LLC

HIPAA Privacy

Please understand there are no exceptions to this policy.



*December 1, 2008
Revised March 15, 2012*

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

[45 CFR 164.520; <http://www.hhs.gov/ocr/hipaa/guidelines/notice.pdf>]

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice of Privacy Practices describes how Happy Brain Counseling, L.L.C., and its employees, volunteers and clinics may use and disclose your protected health information (PHI) for purposes of treatment, payment and health care operations, and for other purposes that are permitted or required by law.

I. RESPONSIBILITIES:

Happy Brain Counseling, L.L.C., takes the privacy of you and/or your child's health information seriously. This clinic is required by law to maintain the privacy of your health information and provide you with this Notice of Privacy Practices. This clinic will abide by the terms of this Notice of Privacy Practices. We reserve the right to change this Notice of Privacy Practices and to make any new Notice of Privacy Practices effective for all protected health information that we maintain. Any new Notice of Privacy Practices adopted will be posted in the waiting area.

II. WHAT IS "PROTECTED HEALTH INFORMATION" (PHI)?

Protected health information ("PHI") is demographic and individually identifiable health information that will or may identify the patient and relates to the patient's past, present or future physical or mental health or condition and related health care services.

III. WHAT DOES "HEALTH CARE OPERATIONS" INCLUDE?

Health care operations include activities such as communications among health care providers, conducting quality assessment and improvement activities; making travel arrangements to and from this clinic; coordinating temporary housing; evaluating the qualifications, competence, and performance of health care professionals; training future health care professionals; contracting with insurance companies; conducting medical review and auditing services; compiling and analyzing information in anticipation of or for use in legal proceedings; and general administrative and business functions.

IV. HOW IS MEDICAL INFORMATION USED?

This clinic uses medical records as a way of recording health information, planning care and treatment and as a tool for routine health care operations. Your insurance company may request information such as procedure and diagnosis information that we are required to submit in order to bill for treatment we provide to the patient. Other health care providers or health plans reviewing your records must follow the same confidentiality laws and rules required of this mental health clinic.

Patient records are also a valuable tool used by our researchers in finding the best possible treatment for diseases and medical conditions. All mental health researchers must follow the same rules and laws that other health care providers are required to follow to ensure the privacy of patient information. Information that may identify patients will not be released for research purposes to anyone outside of this clinic without written authorization from the patient or the patient's parent or legal guardian.

V. EXAMPLES OF HOW MEDICAL INFORMATION MAY BE USED FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

- Medical information may be used to justify needed patient care services, (i.e., lab tests, prescriptions, treatment protocols, research inclusion criteria).
- We will use medical information to establish a treatment plan.



- We may disclose protected health information to another provider for treatment (i.e. referring physicians, specialists and providers).
- We may submit claims to your insurance company containing medical information and we may contact their utilization review department to receive pre-certification (prior approval fortreatment).
- We may use the emergency contact information you provided to contact you if the address of record is no longer accurate.
- We may contact you to remind you of the patient's appointment by calling you or mailing apostcard.
- We may contact you to discuss treatment alternatives or other health related benefits that may be of interest.
- We may use information for making travel arrangements to and from this mental health clinic.
- We may use information to coordinate temporary housing at such facilities as Ronald McDonald House, Target House, and / or local hotels.
- The patient's name, home address, location, and dates of service.

VI. WHY DO I HAVE TO SIGN A CONSENT FORM?

When you, as the patient or the parent or guardian of a patient, sign a consent form, you are giving this clinic permission to use and disclose protected health information for the purposes of treatment, payment and health care operations. This permission does not include psychotherapy notes, psychosocial information, alcoholism and drug abuse treatment records and other privileged categories of information which require a separate authorization. You will need to sign a separate authorization to have protected health information released for any reason other than treatment, payment or healthcare operations.

VII. WHAT ARE PSYCHOTHERAPY NOTES?

Psychotherapy notes are notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session that are separated from the rest of the patient's medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

VIII. WHAT IS PSYCHOSOCIAL INFORMATION?

Psychosocial information is information provided to your social worker regarding your family's social history and counseling services you have received.

IX. WHY DO I HAVE TO SIGN A SEPARATE AUTHORIZATION FORM?

In order to release patient protected health information for any reason other than treatment, payment and health care operations, we must have an authorization signed by the patient or the parent or guardian of the patient that clearly explains how they wish the information to be used and disclosed. The following are some examples of releases of information that require a separate authorization:

- Psychotherapy notes
- Psychosocial information
- The sharing of information and photographs with ALSAC for its fundraising and public relationsactivities
- Use of information in scientific and educational publications, presentations and materials related to the work at this mental health clinic.
- The sharing of information with other clinical and scientific Cooperative Groups that this clinic collaborates with to further care through research and treatment.



X. CAN I CHANGE MY MIND AND REVOKE AN AUTHORIZATION?

You may change your mind and revoke an authorization, except (1) to the extent that we have relied on the authorization up to that point, (2) the information is needed to maintain the integrity of the research study, or (3) if the authorization was obtained as a condition of obtaining insurance coverage. All requests to revoke an authorization should be in writing.

XI. SHARING INFORMATION WITH ASSOCIATES

There are some services provided to this clinic through contracts with business associates. Examples include billing services, transcription services, etc.. When these services are contracted, we may disclose your health information to the business associate so that they can perform the job we have contracted them to do. To protect your health information, we contractually require our business associates to follow the same confidentiality laws required of this clinic.

XII. WHEN IS MY AUTHORIZATION / CONSENT NOT REQUIRED?

The law requires that some information may be disclosed without your authorization in the following circumstances:

- In case of an emergency
- When there are communication or language barriers
- When required by law
- When there are risks to public health
- To conduct health oversight activities
- To report suspected child abuse or neglect
- To report SIDS
- To specified government regulatory agencies
- In connection with judicial or administrative proceedings
- For law enforcement purposes
- To coroners, funeral directors, and for organ donation
- In the event of a serious threat to health or safety

XIII. YOUR PRIVACY RIGHTS

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

1. You have the right to inspect and copy your health information.

This means you may inspect and obtain a copy of your PHI that is contained in a “designated record set” for so long as we maintain the PHI. A designated record set contains medical and billing records and any other records that this clinic uses in making decisions about your healthcare. You may not however, inspect or copy the following records: psychotherapy and psychosocial notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and certain PHI that is subject to laws that prohibit access to that PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have the right to have this decision reviewed. Please contact the HIPAA Privacy Officer if you have questions about access to your medical record.

2. You have the right to request a restriction of your health information.

This means you may ask us to restrict or limit the medical information we use or disclose for the purposes of treatment, payment or healthcare operations. Camille Bruton Reinhold, LPC, is not required to agree to a restriction that you may request. We will notify you if we deny your request. If we do agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by contacting the HIPAA Privacy Officer.



3. You have the right to request to receive confidential communications by alternative means or at alternative locations.

We will accommodate reasonable requests. We may also condition this accommodation by asking you for an alternative address or other method of contact. We will not request an explanation from you as the basis for the request. Requests must be made in writing to the HIPAA Privacy Officer.

4. You have the right to request amendments to your health information.

This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with the HIPAA Privacy Office and we may prepare a rebuttal to your statement and will provide you with a copy of this rebuttal. If you wish to amend your PHI, please contact this clinic and/or the HIPAA Privacy Officer. Requests for amendment must be in writing.

5. You have the right to receive an accounting of disclosures of your health information.

You have the right to request an accounting of certain disclosures of your PHI made by this clinic. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for our Hospital Directory, to family or friends involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to this clinic or the HIPAA Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years.

6. You have the right to receive a paper copy of this Notice of Privacy Practices.

XV. WHAT IF I HAVE A QUESTION / COMPLAINT?

Please contact Camille Reinhold via the telephone provided to you and provided a written summary of your question or complaint. If you have additional questions or concerns please contact the HIPAA privacy officer for this region of Missouri within 180 days of the complaint:

Region VII
Office for Civil Rights
U.S. DHHS
601 East 12th Street, Room 248
Kansas City, MO 64106
(816) 426-7277 Office
(816) 426-7065 (TDD)
(816) 426-3686 Fax