New Patient Information Sheet

Patient Information									
Social Security Number	Title	Last Name			First Name			MI	
Street Address							Apartment #		
City			State	Zip Code			Date of Birth		
Cell Phone		Home Phone			Work Phone				
Marital Status	Student	Gender	Employer						
Employer's Address									
City			State	Zip Code					
Emergency Contact Name		Relationship			Phone Number				
Financially Responsible Party (If Other Than Patient)									
Social Security Number	Title	Last Name			First Name			MI	
Street Address							Apartment Number		
City			State	Zip Code			Date of Birth		
Cell Phone		Home Phone			Work Phone				
Marital Status	Student	Gender	Employer						
Employer's Address									
City			State	Zip Code					
Insurance Information									
Primary Insurance Company		Policy Number			Group Number				
Secondary Insurance Company		Policy Number			Group Number				
Referral Information									
Referring Physician Name		Practice Name			Phone Number				

I, _____, hereby assign payment of any medical benefits to which I am entitled to be made to me or, on my behalf, for any services furnished to me by my physician/therapist. I authorize assignee to release any and all medical information necessary to secure payment for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signature_____ **Date**_____

I understand that I am financially responsible for all charges, wether or not paid by my insurance carrier. Including, but not limited to, any collection and/or attorney fees incurred in the process of collecting payment for services furnished to me.

Signature_____ **Date**_____

Southeastern Success Center, LLC / Midlands Psychiatric Services
Mary "Molly" Bridges, LPC NCC MAC

125 Alpine Circle, Columbia, SC 29223 **phone 803-779-3548**

POLICY, FEES, PAYMENT, INSURANCE AND SCHEDULING

The initial fee for services is $180.00 and the follow-up fee is $150.00 for 50-55 minutes. Sliding scale fees may also apply. Please plan to pay the full fee after each session unless otherwise arranged in advance. You will not be billed. However, a copy of your charges and payment record will be made available upon your request. You may pay with cash, credit or debit card, or a check made out to Midlands Psychiatric and TMS Center of Columbia.

Your appointment time is reserved for you alone. Without sufficient prior notice, it cannot be given to anyone else. **You will be charged the full fee for any missed appointments unless our office staff receives a cancellation notice 24 hours in advance.** Appointments will be scheduled after sessions or you can call the office staff at **803-779-3548**.

Our office staff will file with insurance companies and they will be glad to provide whatever information your particular plan requires so that you may file for reimbursement. Companies often require that a diagnosis be assigned before they will pay. If you find that this is necessary with your plan, I will advise you of my choice of a diagnosis for insurance purposes at your request.

Insurance companies and policies differ greatly in their choices of what types of providers and mental services are covered. There are sometimes confusing and seemingly arbitrary restrictions on reimbursements. With your permission, our office staff will attempt to provide whatever documentation of your services your company requires. If you are relying on your coverage to pay for therapy, you should get **direct confirmation** from the insurance company that they will pay out-of-network mental health benefits and what percentage they will reimburse. **You are responsible for the full fee at time of service.**

****Please be aware** that using insurance to cover mental health fees is an automatic Release of information to your insurance company.

I have read and understand this policy

Name _____

Signature _____

Date _____

General Consent for Communication Guidelines
Mary "Molly" Bridges LPC NCC MAC

125 Alpine Circle, Columbia, SC 29223 **Phone 803-779-3548**

Because the nature of communications and technology continues to evolve, it is important that we are clear about how we will and will not communicate with each other outside of the therapy hour.

Please initial all statements below with a yes or no answer.

THERAPY

Phone Sessions:

I am only able to conduct therapy sessions via phone in states where I am licensed, which currently is only in South Carolina and Georgia. Insurance will not pay for telephone calls. My general rule is that all therapy is done in person unless we have a clear contract that indicates we will talk on the phone. I understand: yes____no_____

Skype Sessions:

Skype or other video telecommunication methods such as Face Time are not considered a confidential form of therapy. Therefore I do not conduct therapy session via the internet. I understand: yes_____ no _____

COMMUNICATIONS:

May my office staff and I call you at home? yes _____ no _____. May we leave a message at this number? yes _____ no _____.

May my office staff and I call you at work? yes _____ no _____. May we leave a message at this number? yes _____ no _____.

May my office staff and I call you on your cell phone? yes _____ no _____. May we leave a message at this number? yes _____ no _____.

Please note that if I call you after hours on my cell phone, I cannot guarantee that the phone line is secure and confidential. The same is true if you call me on your cell phone at my office. I understand: yes _____ no_____.

Texting:

As our office uses landlines for the sake of your security and confidentiality, we do not use texting as a form of communication. Texting, like email, is not secure. I understand: yes_____ no _____

General Consent for Communication Guidelines page 2

Facebook:

I will not accept Facebook Friend Requests from you or send them to you while you are an active client. I have a Facebook page, but I will not communicate with you as a client on the Wall of that page or via Facebook messaging.

I understand: yes _____ no _____

Email:

Email is to be used only for the purposes of sending psychosocial educational information. I may take as long as 24 hours to respond. **Regarding canceling an appointment, 24 working hours' notice is required for notification by PHONE.** ***Please call our office at 779-3548 between 9 AM and 12 PM, or between 2 PM and 4:30 PM, Monday to Friday to speak to our office staff. Calls outside of those times will be recorded by an answering service and the time of call recorded.*** **Email is not to be used for appointments or to communicate emergency or therapeutic information.** If you do send me information via email, know that all communication via the internet is not considered secure and I will not respond to personal information related to your care. I understand: yes _____ no_____

Payment Methods:

I accept cash, checks and credit cards. If you pay me by check, your check will be deposited into my account. My contracted account for billing purposes is Midlands Psychiatric and TMS Center of Columbia and Southeastern Success Center. LLC and by nature of payments traveling to the bank and being handled by bank professionals, I cannot guarantee your confidentiality. If you have concerns about this method of payment, you may pay me by cash or credit card. My credit card contracted account for business is also Midlands Psychiatric and TMS Center of Columbia and Southeastern Success Center. LLC. I understand: yes _____ no _____

If we are taking a credit card payment over the phone, our office staff will call you each time a transaction will be made. I understand: yes_____ no _____

I have read and understand all of the above guidelines for communication and consent to follow them in my therapeutic relationship with Mary "Molly" Bridges, LPC NCC MAC

Signature _____ Date: _____

Southeastern Success Center, LLC / Midlands Psychiatric Service

Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____, and me/us, Southeastern Success Center, LLC. When we use the words "you" and "your" below, this can mean you, your child, or a person for whom you are the legal or personal representative if you have written his or her name here:

_____.

When we examine, evaluate, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide what treatment is best for you and to provide this treatment to you. We may also share this information with others to arrange payment for your treatment, to help others provide other treatment to you, or to carry out certain business or government functions.

By signing this form, you are agreeing to let us use your PHI here and to send it to others for the purposes described just above. Your signature below acknowledges that you have read or heard our Notice of Privacy Practices, which explains in more detail what your rights are and how we can use and share your information. If you do not sign this form agreeing to our privacy practices, we cannot treat you, because we need to use your PHI to evaluate, diagnose, and treat you.

In the future, we may change how we use and share your PHI, and so we may change our Notice of Privacy Practices. If we do change it, you can get a copy from our website, southeasternsucesscenter.com, or from our compliance officer, Mary "Molly" Bridges, who can be reached at 803- 779-3548 or successnow@yahoo.com.

After you have signed this consent, you have the right to revoke it by writing to our compliance officer. We will then stop using or sharing your PHI, but if we have already used or shared some of it, and we cannot change that.

_____ ___/___/___

Signature of client or personal representative — Date

_____ _____

Printed name of legal representative — Relationship to client

_____

Description of personal representative's authority

_____

Signature of authorized representative of this office or practice

☐ Copy given to the client/parent/personal representative

[1/1/2017]

Southeastern Success Center, LLC / Midlands Psychiatric Service

Adult Client Information Form

Today's date: ___/___/___

A. Identification

Your legal name: _____ Date of birth: ___/___/___

Other names you have used (maiden, nicknames, aliases): _____

Address: _____ City: _____ State: _____

Zip: _____

Home phone number: _____ Work number: _____

Email: _____

❑ Disability status: _____ ❑·Talk about later

❑ Gender identity: _____ ❑·Talk about later

❑ Sexual orientation: _____ ❑·Talk about later

❑ Racial/ethnic identities: _____ ❑·Talk about later

❑ Religious/spiritual traditions or identity: _____ ❑·Talk about later

Other ways you identify yourself and consider important: _____

B. Emergency information

If some kind of emergency arises and we cannot reach you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

C. Referral

Who gave you my name to call? Name: _____

Address: _____ Phone: _____

How did this person explain how I might be of help to you? _____

Is this person's relationship with you ❑·personal or ❑·professional?

If professional, may I let this person know that you have come to see me? ❑·Yes ❑·No

D. Current problems or difficulties

Please describe the main difficulties that led to your coming to see me: _____

_____

When did these problems start? _____

_____

What makes these problems worse? _____

_____

What makes these problems better? _____

_____

With therapy, how long do you think it will take for these to get a lot better? _____

E. Your medical care

From whom, or where, do you get your medical care? Clinic/doctor's name: _____

Southeastern Success Center, LLC / Midlands Psychiatric Services

Adult Checklist of Concerns

Name: _____ Date: ___/___/____

Please mark all of the items below that apply to you (or the client), and feel free to add any others at the bottom under "Other concerns or issues." You may add a note or details in the space next to the concerns checked. For a child, mark any of these and then complete the Child Checklist of Characteristics. When you are done, please read the note at the end.

- ❑ I have no problems or concerns at this time
- ❑ Abuse—physical, sexual, emotional; neglect; cruelty to animals
- ❑ Adjusting or adapting poorly
- ❑ Alcohol/drugs (for myself): Prescription medications, over-the-counter meds, street drugs
- ❑ Alcohol/drugs (in my family): Prescription meds, over-the-counter meds, street drugs
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness, worrying
- ❑ Attention or concentration difficulties, distractibility
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion, disorganized thoughts
- ❑ Compulsions, having to say or do certain things
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions and actions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying, inactivity
- ❑ Eating problems: Overeating, undereating, appetite, vomiting (see also "Weight and diet issues," below)
- ❑ Emptiness feelings
- ❑ Failure
- ❑ Fatigue, tiredness, low energy, low stamina
- ❑ Fear of losing control
- ❑ Fears or phobias
- ❑ Feeling "too good," unrealistic happiness
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Gender identity concerns or questions
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt, shame
- ❑ Hallucinations (hearing, feeling, or seeing things not present)
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Hoarding, excessive collecting
- ❑ Hopelessness
- ❑ Housework/chores: Quality, schedules, sharing duties
- ❑ Inferiority feelings
- ❑ Injuring oneself deliberately

- ❑ Immaturity, irresponsibility, poor judgment, lack of motivation
- ❑ Impulsiveness, loss of control, risky actions
- ❑ Legal involvements, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity, remarriage, disappointments
- ❑ Memory problems, forgetting
- ❑ Menstrual difficulties, PMS, menopause, perimenopause, hormonal changes
- ❑ Mood swings
- ❑ Nervousness, tension
- ❑ Obsessions, repeated thoughts or memories
- ❑ Pain management, chronic pain
- ❑ Panics or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, "laziness"
- ❑ Relationship problems with friends, with relatives, or at school or at work
- ❑ Self-centeredness, selfishness
- ❑ Self-esteem, self-confidence
- ❑ Self-neglect, poor self-care, poor hygiene
- ❑ Separation or divorce
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other problems
- ❑ Shyness, oversensitivity to criticism or rejection
- ❑ Sleep problems: Too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders
- ❑ Suspiciousness
- ❑ Suicidal thoughts
- ❑ Temper problems, low frustration tolerance, irritability, outbursts
- ❑ Threats, violent actions, aggression
- ❑ Traumatic events
- ❑ Unconsciousness, "knocked out"
- ❑ Unusual thoughts or behaviors
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems: Employment, "workaholism," can't keep a job, dissatisfaction, ambition
- ❑ Other concerns or issues: _____

Now go back to each concern you checked, and rate how much difficulty it causes you (or the client): 0 = none or not present now; 1 = mild (lowers quality of life but doesn't limit day-to-day functioning); 2 = mild/moderate (lowers quality of life and functioning); 3 = moderate (worse than 2); 4 = fairly severe impacts and limitations on quality of life and functioning; 5 = severely lowers quality of life and ability to function.

Southeastern Success Center, LLC / Midlands Psychiatric Services

Notice of Privacy Practices

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

Privacy is a very important concern for all those who come to this office and who work here. It is also complicated, because of the many federal and state laws and our professional ethics. Because the rules are so complicated, some parts of this notice are very detailed, and you probably will have to read them several times to understand them. If you have any questions, our compliance officer [Mary "Molly" Bridges, successnpw@yahoo.com] will be happy to help you understand our procedures and your rights.

Contents of this notice of privacy practices

A. Introduction: To our clients

This notice will tell you how we handle your medical information. It tells how we *use* this information here in this office, how we *disclose* (share) it with other health care professionals and organizations, and how you can see it. We want you to know all of this so that you can make the best decisions for yourself and your family. If you have any questions or want to know more about anything in this notice, please ask our compliance officer for answers or explanations.

B. What we mean by your medical information

Each time you visit us or any doctor's office, hospital, clinic, or other health care provider, information is collected about you and your physical and mental health. It may be information about your past, present, or future health or conditions, or the tests or treatment you got from us or from others, or about payment for health care. All this information is called "PHI," which stands for "protected health information" which means its privacy must be protected. This information goes into your medical or health care records in our office.

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

- Your history: Things that happened to you as a child; your school and work experiences; your marriage, relationships, and other personal history.
- Your medical history of problems and treatments.
- Reasons you came for treatment: Your problems, complaints, symptoms, or needs.
- Diagnoses: These are the medical terms for your problems or symptoms.
- A treatment plan: This is a list of the treatments and other services that we think will best help you.
- Progress notes: Each time you come in, we write down some things about how you are doing, what we notice about you, and what you tell us.

- Records we get from others who treated you or evaluated you.
- Psychological test scores, school records, and other evaluations and reports.
- Information about medications you took or are taking.
- Legal matters.
- Billing and insurance information

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

We use PHI for many purposes. For example, we may use it here:

- To plan your care and treatment.
- To decide how well our treatments are working for you.
- When we talk with other health care professionals who are also treating you, such as your family doctor or the professional who referred you to us. When we do this, we will ask for your consent. Almost always, we will also ask you to sign a release-of-information form, which will explain what information is to be shared and why.
- For teaching and training other health care professionals or for medical or psychological research. If we do this, your name will never be shown, and there will be no way they can find out who you are. Before we do this we will ask for your consent and ask you to sign an authorization, so that you will know what information will be shared and why.
- To show that you actually received services from us, which we billed to you or to your health insurance company.
- For public health officials trying to improve health care in this area of the country.
- To improve the way we do our job by measuring the results of our work.

When you understand what is in your record and what it is used for, you can make better decisions about what other persons or agencies should have this information, when, and why.

C. Privacy and the laws about privacy

We are required to tell you about privacy because of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the HIPAA Omnibus Final Rule of 2013. [SC Code of Laws, Title 44- Health, Chapter 66 , Adult Heath Care Consent Act.] HIPAA requires us to keep your PHI private and to give you this notice about our legal duties and our privacy practices.

This form is not legal advice. It is just to educate your about your rights and our procedures. It is based on current federal and state laws and might change if those laws or court decisions change. If we change our privacy practices, they will apply to all the PHI we keep. We will also post the new Notice of Privacy Practices in our office where everyone can see. You or anyone else can also get a copy from our compliance officer at any time. It is also posted on our website at southeasternsuccesscenter.com. We will obey the rules described in this notice.

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

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

Mainly, we will use it here and disclose (share) your PHI for routine purposes to provide for your care, and we will explain more about these below. For other uses, we must tell you about them and ask you to sign a written Release of Information form. However, the HIPAA law also says that there are some uses and disclosures that don't need your consent or authorization which we will explain below in section 3. However, in most cases we will explain the PHI and who it will go to and ask you to agree to this by signing a release-of-information form.

1. Uses and disclosures with your consent

We need information about you and your condition to provide care to you. In almost all cases, we intend to use your PHI here or share it with other people or organizations to provide treatment to you, arrange for payment for our services, or some other business functions called "health care operations." You have to agree to let us use and share your PHI in the ways that are described in this Notice of Privacy Practices. To agree, we will ask you to sign a separate consent form before we begin to treat you. If you do not consent to this, we will not treat you because there is a risk of not helping you if we don't have some information.

a. The basic uses and disclosures: For treatment, payment, and health care operations

Here we will tell you more about how your information will be used for these purposes.

For treatment. We use your information to provide you with psychological treatments or services. These might include individual, family, or group therapy; psychological, educational, or vocational testing; treatment planning; or measuring the benefits of our services.

We may share your PHI with others who provide treatment to you. We usually try to share your information with your personal physician, unless you tell us not to. If you are being treated by a team, we can share some of your PHI with the team members, so that these providers will work best together. The other professionals treating you will also enter their findings, the actions they took, and their plans into your medical record, and so we all can decide what treatments work best for you and follow a treatment plan.

If we want to share your PHI with any other professionals outside this office, we will need your permission on a signed release-of-information form. For example, we may refer you to other professionals or consultants for services we cannot provide. When we do this, we need to tell them things about you and your conditions. Later we will get back their findings and opinions, and those will go into your records here. If you receive treatment in the future from other professionals, we can also share your PHI with them. We can do this only when you give your permission by signing a release-of-information form. This is so that you will know what information is being shared and with whom. These are some examples so that you can see how we use and disclose your PHI for treatment.

For payment. We may use your information to bill you, your insurance, or others, so we can be paid for the treatments we provide to you. We may contact your insurance company to find out exactly what your insurance covers. We may have to tell them about your diagnoses, what treatments you have received, and the changes we expect in your conditions. We will need to tell them about when we met, your progress, and other similar things. Insurers may also look into a few of our patient records to evaluate the completeness of our record keeping.

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

b. Other uses and disclosures in health care

Appointment reminders. We may use and disclose your PHI to reschedule or remind you of appointments for treatment or other care. If you want us to call or write to you only at your home or your work, or you prefer some other way to reach you, we usually can arrange that. Just tell us.

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

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

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

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

2. Uses and disclosures that require your consent

If we want to use your information for any purpose besides those described above, we need your permission on a release-of-information form. If you do allow us to use or disclose your PHI, and then change your mind, you can cancel that permission in writing at any time. We will then stop using or disclosing your information for that purpose. Of course, we cannot take back any information we have used here already or disclosed to anyone with your permission.

As a [member of profession/discipline] licensed in this state, and as a member of this state's [professional association] and [these national associations], I maintain your privacy more carefully than is required by HIPAA. The HIPAA rules are described below, but we will almost always discuss these with you and ask you to sign a release of information so that you are fully informed.

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

The HIPAA laws let us use and disclose some of your PHI without getting your consent or authorization in some cases. Here are some examples of when we might do this. We will almost always notify you if any of these situations occur.

a. When required by law

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

- We have to report suspected abuse [or neglect] of children [elders, frail/disabled persons, etc.] to a state agency.
- If you are involved in a lawsuit or legal proceeding, and we receive a subpoena, discovery request, or other lawful process, we may have to release some of your PHI. We will only do so after telling you about the request and will suggest that you talk to your lawyer.
- We have to disclose some information to the government agencies that check on us to see that we are obeying the privacy laws, and to organizations that review our work for quality and efficiency.

b. For law enforcement purposes

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

c. *For public health activities*

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

d. *For matters relating to deceased persons*

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

e. *For specific government functions*

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

f. *To prevent a serious threat to health or safety*

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

If it is an emergency, and we are unable to get your agreement, we can disclose information if we believe that it is what you would have wanted and if we believe it will help you. When we do share information in an emergency, we will tell you as soon as we can. If you don't approve, we will stop, as long as it is not against the law.

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

We can share some information about you with your family and anyone else you choose, such as close friends or clergy. We will ask you which persons you want us to tell, and what information you want us to tell them about your condition or treatment. You can tell us what you want, and we will honor your wishes as long as it is not against the law.

5. An accounting of disclosures we have made

When we disclose your PHI, we will keep a record of whom we sent it to, when we sent it, and what we sent. You can get an accounting (a list) of many of these disclosures. We may charge you a reasonable fee if you request more than one accounting in any 12-month period. If the records were sent as electronic medical records, we will always record that, and there will be no charge for an accounting.

E. Your rights about your protected health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, rather than at work, to schedule or cancel an appointment. We will try our best to do as you ask, and we don't need an explanation. Sending your information in emails has some risk that these emails could be read by someone else. We can set up a password-protected email service to prevent this, or you may just accept the risk of using emails just for simple messages like changing appointments, and not use it for any PHI or sensitive information. We ask that you be thoughtful before you put any information in an email and not use email for anything you want kept private. By signing the separate consent form, you agree to this use of email. Please note that anything you send us electronically becomes a part of your legal record, even if we do not place it in the chart. Be mindful of this, and please do not forward us emails from third parties or others in your life. It is better to print those out and bring them in to discuss them.
2. You have the right to ask us to limit what we tell people involved in your care or with payment for your care, such as family members and friends. You can ask us face to face, and we may then ask for your written permission. We don't have to agree to your request, but if we do agree, we will honor it except when it is against the law, when there is an emergency, or when the information is necessary to treat you.
3. You have the right to prevent our sharing your PHI with your insurer or payer for its decisions about your benefits or some other uses, if you paid us directly ("out of pocket") for the treatment or other services and are not asking the insurer to pay for those services unless we are under contract with your insurer (on their panel of providers).
4. You have the right to look at the PHI we have about you, such as your medical and billing records. In some very unusual circumstances, if there is very strong evidence that reading this would cause serious harm to you or someone else, you may not be able to see all of the information.
5. You can get a copy of these records, but we may charge you a reasonable cost-based fee. If your records are in electronic form, not on paper, you can ask an electronic copy of your PHI. Contact our compliance officer to arrange how to see your records. Generally we do not recommend that you get a copy of your records, because the copy might be seen accidentally by others. We will be happy to review the records with you or provide a summary to you, or work out any other method that satisfies you.
6. You have the right to add to (amend) your records to explain or correct anything in them. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records or to include your own written statements to correct the situation. You have to make this request in writing and send it to our compliance officer.
7. You have the right to a copy of this notice. If we change this notice, we will post the new one in our waiting area, and you can always get

a copy from the compliance officer.

8. If you have a problem with how your PHI has been handled, or if you believe your privacy rights have been violated, contact our compliance officer. We will do our best to resolve any problems and do as you ask. You have the right to file a complaint with us and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue SW, Washington, DC 20201, or by calling 202-619-0257.
9. We will not in any way limit your care here or take any actions against you if you complain or request changes.

You may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

F. If you have questions or problems

If you have any questions or problems our health information privacy policies, please contact our compliance officer [Mary "Molly" Bridges, 803-779-3548 or, successnow@yahoo.com].

The effective date of this notice is 01 / 01 / 2017 .

SOUTHEASTERN SUCCESS CENTER, LLC / MIDLANDS PSYHIATRIC SERVICE

Agreement for Individual Therapy

I, _____, the client, agree to meet with the therapist named below at the appointment times and places we agree on, starting on ____/____/____ for about ____ sessions of _____ minutes each.

I have read the following materials on therapy, which have been provided to me by this therapist:

1. Notice of Privacy Practices
2. Consent to Use and Disclose Your Health Information
3. Policy, Fees, Payment, Insurance and Scheduling
4. General Consent for Communications Guidelines

I believe I understand the basic ideas, goals, and methods of this therapy. I have no important questions or concerns that we have not discussed. In my own words, I understand the following:

1. According to this therapy, the causes of my problems lie in: _____
2. The main methods to be used in this therapy are: _____
3. During these sessions, we will focus on working toward these goals:
   a. _____
   b. _____
   c. _____
   d. _____

   I understand that reaching these goals is not guaranteed.
4. I understand that I will have to do the following things or take the following actions:
   a. _____
   b. _____
   c. _____
   d. _____

With enough knowledge and understanding, and without being in any way pressured, I enter into treatment with this therapist. I will keep my therapist fully up to date about any changes in my feelings, thoughts, and behaviors. I expect us to work together on any difficulties that occur, and to work them out in my long-term best interest. This commitment also shows my therapist's willingness to use and share his or her knowledge and skills in good faith.

At the end of _____ meetings, we will evaluate progress and may change parts of this agreement as needed. Our goals may have changed in nature, order of importance, or definition. If I am not satisfied by our progress toward goals, I will work to revise this agreement, and I may stop treatment after meeting with the therapist for one last time.

This agreement shows my commitment to pay for my therapist's services. I agree to pay **Insurance allowable with co-pay or $180 for Intake session and $150 per Regular session** or _____ at the beginning of each session. I agree to pay for un-cancelled appointments or those where I fail to give the agreed-upon notice that I will not attend.* I understand and accept that I am fully responsible for this fee, and that my therapist will help me in getting payments from any insurance coverage I have. I understand that this agreement will become part of my record of treatment.

$150 Charge for missed appointments without 24 hours notice.

Must call during regular business hours to cancel

I also give my permission for the therapist to take notes and to make electronic recordings of our sessions for personal review and use with a consultant, who is also bound by the legal framework of privacy and confidentiality. I understand that any information in this recording that could identify me in any way will not be published or given out without my written consent.

My signature below means that I understand and agree with all of the points above and on the previous page.

_____ ____/____/____

Signature of client Date

I, the therapist, have discussed the issues above with the client. My observations of this client's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

_____ ____/____/____

Signature of therapist Date

❑ Copy accepted by client or ❑ Copy kept by therapist

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.