NEW CLIENT FORMS

Client Information Sheet

Complete the front and the back and be sure to sign the back.

Financial Agreement

Print your name on the blank line at the top of the page and sign at the bottom of the page.

Preferred Method of Contact (pink sheet)

Complete and sign.

Continuity and Coordination of Care

Start with Section II and print your name, date of birth, and social security number.
List your Primary Care Physician's name, address, and phone number.
List any other providers involved in your care.
Be sure to sign the back and check the appropriate boxes.

Notice of Privacy Practices

This is for you to read regarding the HIPAA laws and to keep.

Acknowledgement of Receipt of the Notice of Privacy Practices (yellow sheet)

Please print your name, date of birth, and sign.

New Client Questionnaire

Please complete as fully as possible.

Elizabeth Weingart, LCSW
23 W Main St Edmond, OK 73003
(405) 838-5902

PATIENT INFORMATION SHEET

(Please Print All Information)

THERAPIST NAME/NO.:
PATIENT ACCOUNT NO:

SECTION A - PATIENT INFORMATION

IF PATIENT IS A MINOR, PLEASE CHECK HERE ☐

PATIENT'S NAME: LAST FIRST MIDDLE			GENDER: ☐ MALE ☐ FEMALE	SOCIAL SECURITY NUMBER: / /
ADDRESS:			BIRTH DATE: / / AGE:	HOME PHONE NUMBER: ( )
CITY:	STATE:	ZIP:	CELL PHONE/PAGER NUMBERS: /	WORK PHONE NUMBER:
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED			☐ EMPLOYED ☐ UNEMPLOYED ☐ RETIRED ☐ DISABLED	OCCUPATION:
NO. OF CHILDREN:	AGES:		EMPLOYER ID:	EMPLOYEE NUMBER:
DATE OF INJURY:	DATE SYMPTOMS 1ST APPEARED		EMPLOYER:	
NAME OF PHYSICIAN:			EMPLOYER'S ADDRESS:	
EMERGENCY CONTACT (NAME AND PHONE NUMBER):			REFERRED TO OUR OFFICE BY:	

SECTION B - BILLING INFORMATION

(PLEASE COMPLETE IF PERSON RESPONSIBLE FOR BILL IS NOT THE PATIENT.)

NAME:			RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ MOTHER ☐ FATHER ☐ OTHER _____
ADDRESS:			SOCIAL SECURITY NUMBER:
CITY	STATE	ZIP	EMPLOYER:
HOME PHONE: ( )	WORK PHONE: ( )		EMPLOYER'S ADDRESS:

SECTION C - SPOUSE'S INFORMATION

(IF APPLICABLE AND DIFFERENT FROM SECTION B)

NAME:	SOCIAL SECURITY NUMBER:
EMPLOYER:	EMPLOYER PHONE NUMBER:
EMPLOYER'S ADDRESS:	EMPLOYEE #

SECTION D - INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION		SECONDARY INSURANCE INFORMATION	
COMPANY:		COMPANY:	
ADDRESS:		ADDRESS:	
INSURED (PERSON WHOSE NAME IS ON ID CARD):		INSURED (PERSON WHOSE NAME IS ON ID CARD):	
ID NUMBER:	BIRTH DATE: / /	ID NUMBER:	BIRTH DATE: / /
GROUP NUMBER:		GROUP NUMBER:	
GROUP NAME:		GROUP NAME:	

SECTION E - ADDITIONAL IN. ORMATION ON CHILD PATIENT.

FATHER:	AGE:	MOTHER:	AGE:
PARENTS ARE: ☐ MARRIED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED		CHILD LIVES WITH: ☐ FATHER ☐ MOTHER ☐ GRANDFATHER ☐ GRANDMOTHER	
IF APPLICABLE, NON-RESIDENTIAL PARENT'S ADDRESS:		NON-RESIDENTIAL PARENT'S PHONE NUMBER: ( )	
SCHOOL:		SPECIAL EDUCATIONAL NEEDS:	GRADE:

SECTION F - OTHER PEOPLE LIVING IN HOUSEHOLD

NAME:	AGE:	RELATIONSHIP:
NAME:	AGE:	RELATIONSHIP:
NAME:	AGE:	RELATIONSHIP:
NAME:	AGE:	RELATIONSHIP:

SECTION G - LEGAL INFORMATION

ARE CLAIMS FOR THE REQUESTED SERVICES INVOLVED IN A LAW SUIT OR ANY OTHER LITIGATION? ☐ YES ☐ NO

IF YES, ATTORNEY'S NAME: ADDRESS: PHONE NUMBER:

SECTION H - AUTHORIZATIONS

MEDICARE ONLY

ONE TIME AUTHORIZATION: I request that payment of authorized Medicare benefits be made to me or on my behalf to the undersigned psychologist/social worker for any services furnished by that provider. I authorize any holder of medical information about me to release to the Health Care Financial Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient's Signature Date Signed

CONSENT TO TREATMENT: I hereby grant consent for treatment or services to be provided by the undersigned psychologist/social worker. I also certify that no guarantee or assurance has been made as to the results which may be obtained.

RELEASE OF MEDICAL INFORMATION: I consent to the release of my medical records by the undersigned psychologist/social worker for the purpose of review or audits or for necessary insurance purposes to authorized representatives of my insurance company.

INSURANCE PAYMENT OF BENEFITS: I authorize payment of benefits to be made on my behalf to the undersigned psychologist/social worker for psychological services.

FINANCIAL AGREEMENT: I understand that I am responsible for all fees, regardless of insurance coverage.

_____ _____

Patient's Signature Date Signed

_____ _____

Insured's Signature (If Other Than Patient) Date Signed

NEW PATIENT QUESTIONNAIRE

INSTRUCTIONS: Thank you for taking the time to fill out this form. The following information will be helpful to your therapist in understanding your concerns and formulating a treatment plan for your specific needs. Your insurance company may also require that this information be obtained at the first visit. If you have any questions, please feel free to ask the receptionist or your therapist.

Date: _____

NAME_____ **SOCIAL SECURITY #** _____

Name of Person filling out form (if different than above). Please indicate your relationship to the patient:_____

CURRENT PROBLEM(S) OR CONCERN(S): Use back of form if additional space is needed.

DESCRIPTION OF PROBLEM/CONCERN:

How long has this been a problem/concern? _____

What are your goals for consultation/therapy? _____

_____

SYMPTOMS/CONCERNS: Please check all of the following which apply to you:

- ❑ Marital stress
- ❑ Other family problems
- ❑ Other relationship problems
- ❑ Problems at work/school
- ❑ Health problems
- ❑ Financial problems
- ❑ Legal problems
- ❑ Sad/depressed
- ❑ Tearful/crying spells
- ❑ Loss of appetite
- ❑ Weight loss
- ❑ Weight gain
- ❑ Difficulty sleeping
- ❑ Sleeping more than usual
- ❑ Concentration problems
- ❑ Indecisiveness
- ❑ Confusion
- ❑ Memory problems
- ❑ Quick Change of Moods
- ❑ Irritability
- ❑ Problems controlling thoughts
- ❑ Worry excessively
- ❑ Feeling worthless
- ❑ Lack of interest/enjoyment
- ❑ Feelings of hopelessness
- ❑ Feeling suicidal
- ❑ Thoughts of hurting others
- ❑ Frustration/anger
- ❑ Guilt feelings
- ❑ Problems controlling anger
- ❑ Drug use
- ❑ Alcohol use
- ❑ Take sleeping pills
- ❑ Take pain pills
- ❑ Hard to make friends
- ❑ Feeling lonely
- ❑ Feeling ignored/abandoned
- ❑ Hard to trust anyone
- ❑ Concerns over sexual functioning
- ❑ Restless/Can't sit still
- ❑ Less energy than usual
- ❑ More energy than usual
- ❑ Very talkative
- ❑ Nervous/Tense
- ❑ Panicky
- ❑ Fears/phobias
- ❑ Nightmares/recurring dreams
- ❑ Shaky /Trembling
- ❑ Rapid heart rate
- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ Sweating
- ❑ Fear of losing control
- ❑ Fear of dying
- ❑ Hot or cold spells
- ❑ Dizziness/Faintness
- ❑ Nightmares
- ❑ See or hear things others don't
- ❑ /Watched/talked about by others
- ❑ Feel used by others
- ❑ Feel others wish me harm
- ❑ Socially isolated
- ❑ Breathing problems
- ❑ Heart problems
- ❑ Bowel problems
- ❑ Bladder problems
- ❑ Skin problems
- ❑ Premenstrual/Menstrual problems

NAME _____ DOB _____

CURRENT AND PAST MEDICAL HISTORY:

1. Please list any serious illnesses, injuries or surgeries that you have had in your lifetime, including dates: _____

2. Please identify any medications, foods, or substances for which you are allergic or have sensitivities:
   - ❑ No known medical allergies
   - ❑ Known allergies _____

3. Please identify any of the following substances which you have used, past or present. For those you check, please explain when and the amount used.
   - ❑ Caffeine _____
   - ❑ Tobacco _____
   - ❑ Alcohol _____
   - ❑ Illicit Drugs _____

CURRENT MEDICATIONS:

Name	Dose/Frequency	Reason	Prescribing Physician	Start Date

4. Do you take any other medications, vitamins, or herbal remedies not prescribed by a doctor? If so, please describe: _____

5. Have you ever had problems with the following (past or present)? (Check all that apply):
   - ❑ Seasonal Allergies When: _____
   - ❑ High Blood Pressure When: _____
   - ❑ Heart Disease When: _____
   - ❑ Stroke When: _____
   - ❑ Lung Disease When: _____
   - ❑ Diabetes When: _____
   - ❑ Cancer When: _____
   - ❑ Kidney Disease When: _____
   - ❑ Ulcers When: _____
   - ❑ Seizures When: _____
   - ❑ Thyroid Disease When: _____
   - ❑ Stomach/Intestinal Disease When: _____
   - ❑ Glaucoma When: _____
   - ❑ Any other hereditary diseases? Please explain:

NAME _____ **DOB** _____

6. Date of last medical exam_____ Reason_____ Physician _____

7. Are you currently pregnant? Yes No Number of previous pregnancies, if applicable: _____

8. Have you ever been in a serious accident or had an occasion in which you sustained a head injury or loss of consciousness? Yes No If Yes, please explain_____

_____

9. Are you aware of any of the following factors existing during your prenatal development or birth: (check all that apply)

- ❑ No known complicating factors
- ❑ Maternal alcohol/drug ingestion
- ❑ Paternal alcohol/drug ingestion
- ❑ Rubella
- ❑ Toxemia
- ❑ Fetal malnutrition
- ❑ Fetal malnutrition
- ❑ Premature birth
- ❑ Perinatal Asphyxia (loss of oxygen during birth process)
- ❑ Other _____

PAST PSYCHIATRIC HISTORY:

1. Have you ever been hospitalized for psychiatric reasons or chemical dependency? Yes No

Hospital	Dates	Reason	Treatment

2. Have you had any previous outpatient psychiatric or chemical dependency treatment? If yes, please describe by whom, for what reason, and how long.

_____

_____

3. Have you had any previous psychotherapy? Please describe by whom, reason, and how long.

_____

_____

4. Have you ever attempted suicide? Yes No If yes, describe when , method used, and reason.

_____

5. Please check any of the following that applied to you during your childhood:

- ❑ Night terrors
- ❑ Sleepwalking
- ❑ Bedwetting
- ❑ Nail biting
- ❑ Thumbsucking
- ❑ Stammering/Stuttering
- ❑ Death of parent/caretaker
- ❑ Death of sibling
- ❑ Physical abuse experience
- ❑ Sexual abuse experience
- ❑ Problems with teachers
- ❑ Problems with police
- ❑ School truancy/problems
- ❑ Lying
- ❑ Stealing
- ❑ Fire setting
- ❑ Eating problems
- ❑ Hyperactivity
- ❑ Destructiveness
- ❑ Extreme shyness or fears
- ❑ Wetting or soiling problems

NAME _____ DOB _____

6. In your family, has anyone had the following:

- ☐ Alcoholism Who: _____
- ☐ Drug Abuse Who: _____
- ☐ Depression Who: _____
- ☐ Suicide Attempt Who: _____
- ☐ Completed Suicide Who: _____
- ☐ Anxiety/Panic Who: _____
- ☐ Schizophrenia Who: _____
- ☐ Hyperactivity/ADHD Who: _____

7. **If patient is a minor**, please identify the age at which your child reached the following developmental milestones.

Sat alone _____
Crawled _____
Walked alone _____
Said first word _____
Used two words together _____
Rode a tricycle _____
Dressed him/herself _____
Became toilet trained _____
Learned basic colors _____
Played on own _____

EDUCATION AND EMPLOYMENT HISTORY:

1. Highest grade completed _____

2. Did you ever repeat or skip a grade level? If so, when _____

3. Academic performance during school: (circle all levels that apply)

Elementary School	Above Average	Average	Below Average
Middle School	Above Average	Average	Below Average
High School	Above Average	Average	Below Average
College	Above Average	Average	Below Average

4. Were you ever in Special Education classes in school. If so, please describe. _____

_____

2. If currently a student, please identify where, year/grade level, and area of study. _____

_____

2. If you are a college graduate or completed specialty training, please list degrees and area of specialty.

_____

_____

3. Please describe your current or most recent employment (employer name, job position, length of employment)_____

_____

_____

NAME _____ DOB _____

4. If currently disabled, please describe when you became disabled and the reason. _____
_____

5. If retired, please indicate date that you retired and any volunteer work you may currently do. _____
_____

6. Are you a Veteran? Yes No

SOCIAL/MARITAL HISTORY:

1. Where were you raised and by whom? _____

2. How would you describe yourself as a young child? _____
As a teenager? _____

3. If married, number of marriages, duration of each, and reason for divorce (if applicable)_____
_____
_____

4. Please provide the following information about your parents and siblings

	Age	Location	Education	Occupation	If deceased, cause of death
Father					
Mother					
Bro/Sis					
Bro/Sis					
Bro/Sis					
Bro/Sis					
Bro/Sis					
Bro/Sis					

Are there any other issues that would be important for your therapist to know about?

Authorization for Electronic Communication

As a convenience to me, I hereby request that Elizabeth Weingart, LLC communicate with me regarding my treatment by Elizabeth Weingart, LLC via electronic communications (e-mail or text message). I understand that this means Elizabeth Weingart, LLC and/or my treating providers will transmit my protected health information such as information about my appointments, diagnosis, medications, progress and other individually identifiable information about my treatment to me via electronic communications.

I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, Elizabeth Weingart, LLC shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by Elizabeth Weingart, LLC to me.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize Elizabeth Weingart, LLC to communicate electronically with me, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications from Elizabeth Weingart, LLC, I may revoke this authorization by providing written notice to Elizabeth Weingart, LLC at 23 W Main, Edmond, OK 73003 or fax at 405.563.9089.

I agree that Elizabeth Weingart, LLC may communicate with me electronically unless and until I revoke this authorization by submitting notice to Elizabeth Weingart, LLC in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

I hereby authorize the transmission of my protected health information electronically as described above.

_____
Patient Name

_____ _____
Signature of Patient Date

Continuity and Coordination of Care
Authorization and Release of Information

Communication between and among your **behavioral health care providers** and your **primary care physician** is important for you to receive comprehensive and quality healthcare. We are requesting that you authorize and consent to the exchange of health information between your **health care providers** identified below.

SECTION I:

I**, _____, _____, _____,**
(Client Name-Print) (Client DOB) (Client SS#)

For the purpose of coordinating care, authorize the **health care providers** identified below to exchange information related to my physical and behavioral health evaluations and treatment plans:

_____

Health Care Provider Name (PCP) Phone #:

_____

Address: Fax #:

_____

Behavioral health care provider name Phone #:

_____

Address: Fax #:

_____

Behavior health care provider name Phone #:

_____

Address: Fax:

SECTION II:

I, the undersigned, understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. To revoke this authorization I must send a written request to **Elizabeth Weingart, LCSW** at **23 W Main St, Edmond, OK 73003.**

This authorization continues indefinitely unless revoked in writing or treatment is terminated.

This information is being disclosed on the condition that it not be re-disclosed except as authorized or permitted by applicable Federal or State laws, including the Federal Privacy regulations. I understand that information disclosed pursuant to this authorization may, in some instances, no longer be protected by the Privacy Regulations. Re-disclosure may occur in situations such as if my provider's care is reviewed by a State or Federal agency, a court orders the disclosure of information, or if I sue my provider and my provider needs the information to defend herself.

I understand that I may refuse to sign this authorization. Signing this authorization will not affect my treatment in any way or the payment for the care I receive. I also understand that I may inspect and copy any protected health information to be used or disclosed, except as otherwise limited by applicable laws.

Please check as appropriate:

( ) I give my authorization to release to, obtain from, and discuss with the identified health care providers the following information **(select all that apply)**:____Medical information____HIV status____Substance abuse information____Behavioral health information, excluding "psychotherapy notes" as defined by HIPPA.

( ) I give my authorization to obtain from, release to, and discuss with the identified health care providers **only medication information**.

( ) I **do not** give my consent to release to, obtain from, or discuss with any health care provider any information. I understand that dangerous drug interactions or other adverse medical consequences could occur from my refusal to consent to any exchange of information between my health care providers. I acknowledge that I have been advised to personally provide information to my health providers, especially about my diagnoses and prescribed medications.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

_____	_____
Client Signature	Signature of Authorized Representative
_____	_____
Date	Relationship to Client

FINANCIAL AGREEMENT

Elizabeth Weingart, LCSW
23 W Main St Edmond, OK 73003

PLEASE READ AND SIGN INDICATING THAT YOU UNDERSTAND AND AGREE TO THE FOLLOWING CONDITIONS:

1. A therapist-client relationship is being established between Elizabeth Weingart, LCSW and _____. The therapy "hour" is usually 53 minutes in length. Fee per session is $200.

   I authorize the release of information necessary to process insurance claims and/or secure pre-certification for services.

2. **I agree to pay the co-payment/co-insurance or other portions not covered by insurance AT THE TIME OF SERVICE.** If for any reason the insurance does not pay, I will be responsible for payment. Any special payment plans must be worked out with the therapist.

3. **A 24 hour notice is required for cancellation of an appointment**. If, for any reason, a 24 hour notice is not given, there will be a **charge of $75.00**. If the session is cancelled in the hour prior to the appointment or not at all, a **charge of $100 will be assessed.** Insurance is **NOT** filed for late or missed appointments.

I UNDERSTAND AND AGREE TO THE ABOVE.

CLIENT/GUARANTOR (signature)_____

DATE_____

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Elizabeth Weingart, LCSW
23 W Main St Edmond, OK 73003

Patient/Client Name:_____
DOB: _____
SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Elizabeth Weingart's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Elizabeth Weingart at the address listed above.

_____

Signature of Patient/Client **Date**

_____

Signature or Parent, Guardian or Personal Representative * **Date**

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Staff Member **Date**

Elizabeth Weingart, LCSW
23 W Main St Edmond, OK 73003
405.838.5902

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

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at 23 W Main St, Edmond, OK 73003:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at 405.838.5902 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is August 1, 2016.