**PATIENT INFORMATION**

Patient Name: DOB:

Address:

Home Phone: Consent to leave voice messages?  Yes  No

Work Phone: Consent to leave voice messages?  Yes  No

Cell Phone: Consent to leave voice messages?  Yes  No

Consent to text appointment reminders  Yes  No

Email:

How did you hear about us, or by whom were you referred?

Emergency Contact: Phone Number:

**NOTICE OF PRIVACY PRACTICES**

CPAS strives to protect patient confidentiality; we are required, by law, to maintain the privacy of patients’ Protected Health Information (PHI). Federal legislation requires that we issue this official notice of our privacy practices and abide by the terms herein. If you have any questions about this notice, please ask your practitioner directly.

**Those Subject to this Notice:**

Any health care professional authorized to enter information into your record as well as employees, staff, and other personnel at this practice, who may need access to your information must abide by this too. All business associates, such as representatives of managed care companies coordinating services, must follow these same privacy practices. Please understand that when personal health information is shared, only the minimum necessary information needed to accomplish this task will be disclosed.

**Uses and Disclosures of Protected Health Information Requiring Your Written Authorization:**

In most cases, CPAS will not use or disclose your “Protected Health Information” (e.g., name, date of birth) without your verbal or written authorization except for the reasons described below. Please note, if you provide authorization to use or disclose medical information, you may revoke that authorization, in writing, at any time. If you revoke authorization, we will, thereafter, no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we may have already made with your authorization. Furthermore, you agree and understand that we are required to document and retain a written record of the care we have provided you.

**How We may Use and Disclose Medical Information Without Your Authorization:**

There are limited circumstances where an authorization is not needed for disclosure of personal information. Most, but not every possible use or disclosure category are listed below. This notice applies primarily to information contained in your medical and billing records. More detailed and personal information contained in practitioners’ “psychotherapy notes” are kept separately and are given an even greater degree of privacy and protection than the personal health information contained in your medical and billing records. As such, these would require written authorization even for the standard disclosure exceptions listed below.

**Disclosure for Third Party Billing (e.g., court requested assessments, fitness-for-duty/military assessments):**

When a third party requests an assessment, we require written authorization by all parties prior to the intake. Please be aware that the final assessment will be the property of the payor. You may receive a copy of the final report only if allowed by the referring party. The final report will be directly sent to the third-party organization.

**Other Uses or Disclosures That Can be Made Without Consent or Authorization:**

* To avert serious threat to health or safety for you or others.
* To report neglect or abuse of vulnerable populations (e.g., child/elder/functionally impaired).
* To comply with court orders.

**Your Rights Regarding Complaints Concerning Use or Disclosure of Your Health Information:**

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services whose address will be provided to you, at your request. All complaints must be submitted in writing.

**Right to Request Restrictions:**

You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, CPAS is not required to automatically agree to a restriction you request. Your request must be in writing and specifically state what information you wish to limit.

**Right to Receive Confidential Communications by Alternative Means and at Alternative Locations**:

You have the right to request and receive confidential communications of private health information by alternative means and at alternative locations. (For example, you may not want a family member to know that you are a patient at this practice). Upon your request, this practice will send correspondence to another address or arrange to call you only at work, instead of home.

**Right to Inspect and Copy:**

Except in the most unusual circumstances, whereby, the practitioner may decide to restrict access to the medical record for the purposes of protecting patient information (e.g. court ordered evaluations, child custody cases), you have the right to inspect and/or obtain a copy of your private health information in the medical record. You also have a right to request statements detailing billing for services. This information will be maintained for the required length of time, as defined by the rules that govern record maintenance. Upon your request, your practitioner will discuss with you the details of the request process.

**Right to Amend:**

You have the right to request an amendment of private health information, as it is maintained in the record. Your practitioner may deny your request, if, in his/her opinion, the amendment would compromise the accuracy of your medical information.

**Changes to this Notice:**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you, as well as any information we receive in the future.

**CONFIDENTIALITY STATEMENT**

**Confidentiality Statement:**

CPAS will not release any information regarding your history or treatment without expressed permission from you or your guardian/parent. We will have you sign a release of information for our files. We are obligated to, and will, take every reasonable step, to protect your privacy as a standard of ethical and professional practice.

**Exceptions:**

There are several exceptions to this general policy; whereby, the state laws require that we break confidentiality. While the list below covers the major areas in which this can occur, the list does not cover every instance. By signing this form, you acknowledge the following:

* Your receipt and understanding of these limitations.
* Your understanding of the right to ask your practitioner about the limits of confidentiality at any point during your treatment.

1) The law requires that practitioners report any suspicion of child abuse and/or neglect to the New Hampshire Division of Children, Youth, and Families (DCYF). Practitioners are also required to report suspicion of abuse or neglect of senior adults or vulnerable adults to the Bureau of Elderly and Adult Services (BEAS). We are mandated reporters. When we have a reasonable basis to suspect abuse or neglect of the populations mentioned above, we are required to report that information to the appropriate agency.

2) If anyone in this agency or your practitioner observes or comes to know of a serious threat or risk of danger to you or others, we may be required to act to protect you or them, thus, creating the possibility for disclosure of otherwise confidential information, in order to meet our legal duty.

3) In rare instances, a court order may be issued at the request of an individual or agency seeking access to your clinical record. CPAS and all providers must comply with court orders.

If you have signed CPAS releases to provide information to others, you should remember that you may cancel these releases at any time; however, any information released prior to your withdrawal of permissions cannot be recovered.

**INFORMATION POLICY STATEMENT**

The New Hampshire Board of Psychology requires all licensed psychologists to provide patients with specific information, which is posted in the waiting room. Please read it carefully and discuss any questions you have before signing below.

**Cancellation/Rescheduling Policy:**

If you must cancel an appointment, we require a minimum of 48 hours advance notice to avoid cancellation fees. If the minimum is not provided, you will be charged $200 for the intake appointment or the feedback meeting. A $300 cancellation fee will be charged for all testing appointments canceled later than 48 hours.

You may call the office and leave a voicemail, at any time, to cancel your appointment (our phone system timestamps your call). Lastly, we reserve the right to terminate the contract if you cancel without prior notice three consecutive times. We will retain payment collected for clinical services rendered and any cancellation or late rescheduling fees previously charged.

**Billing Policies and Procedures:**

Please refer to the CPAS Fee Schedule and Payment Contract Form for information for Billing Policies and Procedures. Bank fees charged for returned checks will be added to patient account balance.

If you are referred for assessment, CPAS has additional paperwork for you to review and sign. CPAS requires all assessment patients or their parents to sign a Fee Schedule and Payment Contract Form.

**HIPAA EMAIL INFORMATION**

1. HIPAA stands for the Health Insurance Portability and Accountability Act.

2. HIPAA was passed by the U.S. government in 1996 to establish privacy and security protections for health information.

3. Information stored on our computers is encrypted.

4. Most popular email services (e.g., Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email. We recommend the use of HIPPA compliant software when transmitting information. CPAS utilizes such.

5. Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA. The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website‐ [http://www.gpo.gov/fdsys/pkg/FR‐2013‐01‐25/pdf/2013‐01073.pdf](http://www.gpo.gov/fdsys/pkg/FR%E2%80%902013%E2%80%9001%E2%80%9025/pdf/2013%E2%80%9001073.pdf)

6. CPAS will not send personal health information using unencrypted email. However, should you and your practitioner decide to use CPAS’s HIPAA compliant email and/or video conference web portal, we will send a link to your personal email, so that you may sign up for the service.

**AFTER HOURS EMERGENCY SERVICES**

**Emergency Coverage:**

If you experience a psychiatric emergency after hours, please contact Riverbend Community Mental Health, Inc., Emergency Services (1-833-710-6477 or nh988.com). If you are experiencing a psychiatric emergency and you live outside of Merrimack County, please contact your local community mental health center, your local hospital emergency room, or dial 911.