Solutions 4 Kids
Linda Wiskerchen, LCSW

11011 S. 48th Street Suite #101 Phoenix, AZ 85044
(480) 861-9624
www.Solutions4kids.org

NEW CLIENT REGISTRATION

Today's Date_____
Child's Name: _____ DOB: ___/___/____ Age: _____

Child's Primary Residence: _____ City: _____ Zip: _____
Caregiver (s) at this address: _____
Is it okay to send correspondence/billing to this address? Yes No If no, please provide an alternate address:
_____

Second Residence _____ City: _____ Zip: _____
Caregiver (s) at this address: _____

Relationship Status of Child's Parents: Married * Divorced * Separated * Widowed * Other
If divorced, what is the custody agreement? _____

Mother: _____
Occupation: _____
Employer: _____
Home phone: (____) _____
Cell phone: (____) _____
Email: _____

Father: _____
Occupation: _____
Employer: _____
Home phone: (____) _____
Cell phone: (____) _____
Email: _____

If applicable:
Step-Mother: _____
Occupation: _____
Employer: _____
Home phone: (____) _____
Cell phone: (____) _____
Email: _____

Step-Father: _____
Occupation: _____
Employer: _____
Home phone: (____) _____
Cell phone: (____) _____
Email: _____

Okay for therapist to email or text to the cell#'s listed above to confirm appointments? Yes No
Okay for therapist to leave a brief message on the phone numbers listed above? Yes No
Okay for therapist to send newsletter and practice updates to the emails above? Yes No

Referred by: Insurance Co. Physician Friend Google Ad Website Other:_____

May I have permission to thank the person that referred you? Yes No

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INTAKE QUESTIONNAIRE

Child's Name: _____ DOB: _____ Age: _____

Person completing form: _____

Please list **all those living in your home** besides the child. This includes spouse, siblings, partner, friends and relatives. *Please use the back of this form if needed.*

Name	Age	Gender	Relationship to Child
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	

Separation/Divorce:

Are parents separated or divorced? ☐ Yes ☐ No If yes, for how long? _____
If parents are separated/divorced, does non-custodial parent share legal custody? ☐ Yes ☐ No
Are both parents aware that this child will be receiving counseling? ☐ Yes ☐ No
Does child have contact with both parents? ☐ Yes ☐ No How often? _____

Counseling History

Has your child previously received counseling? Yes No If yes, when and for what?

_____

Do you think that it was a positive experience for your child? Yes No
Was it a positive experience for both parents? Yes No
Has your child received medication for behavior or moods? Yes No
If yes, what was the outcome? _____

Please complete the following questions:

How well does your child fall asleep, stay asleep and wake up from naps and in the morning?

_____

Does your child show any separation anxiety/fears at home or school? Yes No If yes, please describe: _____

_____

What is your child's favorite thing to do? _____
What are your goals for your child's therapy? _____

_____

_____

What is the most important thing that I can do for you today? _____

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Child's Name: _____

Medical History

Pediatric office: _____ Doctor: _____
Address: _____ Phone: _____
Does your child have any **current** or **past** medical or physical concerns? ☐ Yes ☐ No
If yes please describe: _____
Has your child had any of the following? If yes, please explain:
Head injuries? ☐ Yes ☐ No If yes, did child lose consciousness? ☐Yes ☐ No _____
Hospitalizations? ☐ Yes ☐ No _____
Surgeries? ☐ Yes ☐ No _____
Medical procedures? ☐ Yes ☐ No _____
Seizures? ☐ Yes ☐ No _____
Serious illness ☐ Yes ☐ No _____

☐ hearing difficulties ☐ eye/vision problems ☐ asthma
☐ sensory problems (i.e. doesn't want to touch certain textures; bothered by bright lights)
☐ fine motor problems (handwriting, cutting, using fingers)
☐ gross motor problems (clumsy, poor balance, trouble running)
☐allergies (food, pet, etc) ☐ Yes ☐ No If yes, what? _____

Current Medications: please add additional information on back if needed.

Name of Medication	Dose/frequency	Reason	How long prescribed	Prescribing Doctor

Prenatal/Birth History

Did mother receive prenatal care? ☐ Yes ☐ No
Were there any complications during: Pregnancy ☐ Yes ☐ No _____
Labor ☐ Yes ☐ No _____
Delivery ☐ Yes ☐ No _____
Was child born premature or full-term? _____ Vaginal or Caesarian? _____
Child's Weight at birth _____
Was there an extended hospital stay for mother or child after delivery? ☐ Yes ☐ No _____
Did child spend any time in the NICU? ☐ Yes ☐ No _____
Alcohol or drug use during pregnancy? ☐ Yes ☐ No _____
Use of medication during pregnancy? ☐ Yes ☐ No _____
Did mother have post-partum depression? ☐ Yes ☐ No _____

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Child's Name:_____

Please check any items below that your child experienced as an infant or toddler:

__ Exposure to lead	__ Repetitive movements
__ Walking/gross motor delay	__ Difficult to comfort
__ Speech/Language delay	__ Eating non-foods
__ Hand coordination/fine motor delay	__ Overly social/friendly
__ Poor attachment to parents/caregivers	__ Slow response when called by name
__ Sleeping difficulties	__ Avoidance of eye contact
__ Problems eating	__ Separation from parents
__ Not wanting touch	__ Loss of previous abilities
__ Clingy	__ Other _____

Please note any delays or concerns with following milestones:

Sitting _____	First word _____
Crawling _____	Two-word sentences _____
Standing _____	Toilet trained _____
Walking _____	Imitates others _____

Childcare

Childcare: _____ Phone# _____

☐ center ☐ home daycare ☐ in your home ☐ before/after school ☐ friend/neighbor

☐ other_____ #Days/week:____ #hours/day: ___ # Children in facility:_____

Has child been asked to leave any childcare? ☐ no ☐yes

Education

School: _____ Grade: _____ Teacher _____

Has your child attended other schools? ☐ No ☐ Yes : How many? _____

What prompted the change? _____

Overall, how is your child's academic progress? ☐ excellent ☐good ☐fair ☐poor ☐ struggling

Does your child receive any special services?

☐ tutoring (in school/ private) ☐ occupational/speech/physical therapy ☐ 504 plan ☐ IEP

☐ Other_____

Have you ever been called to pick your child up at school due to misbehavior? ☐ No ☐ Yes

_____

Has your child ever had detention, been suspended or asked to leave a school? ☐ No ☐ Yes

_____

Does child ever report not liking school or teachers? ☐ No ☐ Yes

Homework time is: Easy Moderately Challenging Difficult Impossible

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Child's Name:

Child and Family History - Please indicate any that child has experienced:

___ Parent injury/ illness/hospitalization
___ Unemployment of family member
___ Alcohol or drug abuse by family member
___ Abuse (Sexual, emotional, verbal, physical)
___ Violence in the home
___ Violence in the community
___ Family members that have been arrested
___ Family members that have been incarcerated
___ Police confrontation/arrest of parent/guardian
___ Death in the family
___ Conflict between parents
___ Witness to drug abuse
___ Financial stress for caregiver
___ Exposure to a traumatic event
___ Car accident
___ Home robbery/invasion
___ Disaster (natural/other)
___ Frequent moves

Family Mental Health History – *Family history is important to understanding your child's behavior and treatment. Please indicate below if anyone in the family has experienced the following.*

Has anyone experienced:	**Mother's Side**	**Father's Side**
Anxiety		
Depression		
Bipolar disorder		
Learning disorders (ADHD, dyslexia…)		
Drug abuse		
Alcohol abuse		
Schizophrenia		
Suicide attempts		
Completed suicide		
Panic Attacks		
Collecting useless items		
Violent temper		
Abuse (Physical/ Emotional/ Verbal / Sexual)		
Hallucinations or Delusions		
Strange behavior or thinking		

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Please check items that describe your child's behavior for the **6 months:**

□ Academic problems/homework difficulties	□ Nightmares, night terrors
□ Angry mood/Rages/Yelling	□ Paying attention; focusing difficulties
□ Anxiety	□ Perfectionism
□ Arguing	□ Playing with fire
□ Being bullied or bullying	□ Repetitive habits
□ Blames others	□ Rigid routines
□ Bossiness	□ Unusual behavior
□ Confused thinking	□ Self injury
□ Crying frequently	□ Separation anxiety
□ Defiant (to parents or other adults)	□ Sexualized behavior (that seems inappropriate)
□ Destroys things	□ Shyness (excessive)
□ Disorganized, loses things	□ Sleeping, waking difficulties
□ Doesn't want to try new things	□ Somatic complaints (headaches/stomachaches)
□ Eating issues (too much, too little)	□ Stealing
□ Easily frustrated	□ Strong feelings of guilt or shame
□ Emotional outbursts	□ Suicide attempts
□ Fears	□ Suicidal thoughts (says wants to die)
□ Forgetfulness	□ Talking back
□ Frequent conflict	□ Tantrums
□ Grief/loss	□ Threats or comments about hurting self
□ Hair pulling	□ Threats or comments about hurting others
□ Hard to make/keep friends	□ Too concerned with neatness
□ Hears or sees things others do not	□ Toileting
□ Hits others	□ Transitions are difficult
□ Hurts animals	□ Strong reactions to textures, light, sound
□ Hyper; trouble sitting still	□ Unhappy, sad or depressed
□ Impulsive	□ Unusual thoughts
□ Irritable	□ Wetting/ soiling pants or bed
□ Lack of confidence	□ Withdrawn; not sociable
□ Learning and remembering difficulties	□ Worries a lot
□ Mood quickly goes up and down	□ Yelling

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Treatment Plan for _____ *(child's name)*

The main GOALS that I/We have for this child's therapy are:

1. _____
2. _____
3. _____

Therapist will complete this section with you:

Treatment Methods Include: Individual Child Therapy, Parent Consultation, Family Therapy, CBT, Psycho-education, Play Therapy, Expressive Arts Therapy, Relaxation/Mindfulness Skills

Attend session _____

Other Recommendations:
Couples/Family Counseling; Psychiatric Assessment; Follow-up with Medical Practitioner, OT asst
Other: _____

Plan to be reviewed on : ___/___/___

Parent Signature _____ Date: _____

Parent Signature _____ Date: _____

Minor Signature _____ Date: _____

Therapist _____ Date: _____
Linda Wiskerchen, LCSW

Plan Reviewed: ___/___/___ [ ] Continue with goals above and/or [ ] Add new goal(s) below:

1. _____
2. _____
3. _____

Parent Signature _____ Date: _____

Parent Signature _____ Date: _____

Minor Signature _____ Date: _____

Therapist _____ Date: _____
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AUTHORIZATION TO BILL CREDIT CARD

I, _____ hereby authorize Linda Wiskerchen, LCSW, RPT-S, to bill my credit card:

Account # _____ Exp. Date _____

Security Code # _____

Name as it appears on the card _____

Address _____ City_____

State _____ Zip Code _____ Phone Number: _____

I furthermore understand that a **48-hour cancellation time frame** is needed to cancel appointments and that I am fully financially responsible for client services including any **"No-Show" or "Late Cancellation" or "Missed"** appointments. The fee for **"No-Show," "Late Cancellation" or "Missed"** appointments is **$150.00.**

I also understand that by using a credit card, a **$3.00** service charge will be added to all credit card transactions.

_____ _____

Authorized Signature Date

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Informed Consent for Assessment and Treatment

The purpose of this document is to help you make an informed decision about participating in treatment. Please read it carefully and discuss with me any questions that you may have. A copy of this form is available upon request.

About the Therapy Process

It is important for you to know that child & family therapy has risks and benefits. Therapy often requires recalling unpleasant events and struggling with troubling issues. Consequently, people sometimes experience uncomfortable feelings such as sadness, fear, or loneliness and family distress or concerning behaviors may increase. However, therapy has been shown through research to be beneficial to adults, children, couples, and families. Although there are no guarantees about the outcomes of therapy, families can experience improved closeness and communication and children and adolescents often demonstrate a reduction in concerning behaviors and an increase in emotional well-being. I utilize individual child therapy, play therapy, parent support and consultation, family therapy, social skill building, cognitive behavioral therapy, expressive arts therapy and relaxation/mindfulness skills in my work with children and families.

Parent involvement is an integral part of child therapy. Sessions may include parent involvement in the session, sometimes through talk and sometimes through an activity or play. When parents are willing to join their children in a playful manner, it can greatly increase the effectiveness of therapy sessions.

An important part of child therapy includes regular meetings with parents. These meetings are an essential part of your child's growth in therapy. During these meetings, we will discuss your child's progress in therapy, changes in behavior at home and school and your ongoing concerns. We may also discuss family history and family interactions as relevant to treatment. Consultation, and education will be provided if needed. Parents will often ask: How long does (play) therapy take? Each play therapy session varies in length but usually last about 30 to 50 minutes. Sessions are usually held weekly. Research suggests that it takes an average of 20 play therapy sessions to resolve the problems of the typical child referred for treatment. Of course, some children may improve much faster while more serious or ongoing problems may take longer to resolve.

If you have information that you want me to know before a session with your child, please email or call me 24 hours before the session so that I have time to receive the information and plan the session accordingly.

Custody/Guardianship

Consent for services can only be authorized by a current legal guardian. For divorced parents, consent may be given by the parent authorized to make medical decisions. If parents hold joint custody regarding medical decisions, consent of both parents is required. **A copy of the divorce decree must be included in the client file indicating the custodial arrangement. Permission from both parents, regardless of the custodial arrangement is the practice of this office.**

About Me

I am a private practitioner in this office and hold no formal or legal association to the other practitioners providing behavioral health services in this office/suite. I am licensed with the State of Arizona Board of Behavioral Health Examiners to practice independently as a Licensed Clinical Social Worker-Clinical Supervisor. I

have a master's degree in Social Work. I am Registered Play Therapist-Supervisor. I am certified by the Arizona Association for Play Therapy.

Client Rights

1. You have the right to ask questions about and /or refuse any therapeutic technique or recommended treatment and the right to be advised of the consequences of such refusal or withdrawal.
2. You have the right to end therapy at any time without any moral, legal or financial obligations other than those already accrued. If you wish. I will provide you with the names of other qualified therapists.
3. You have the right to participate in treatment decisions and in the development and periodic review and revision of your treatment plan.
4. You have the right to request your medical and billing records. Please see HIPAA form for procedure.

Therapy Services and Fees

1. **Session Fee:** A therapy hour is **50 minutes**. My standard fee is $150 per 50-minute session. I request payment of fee or co-payment at the time of service. If you are on a Health Plan for which I am a provider I will bill your insurance company for you. Any deductibles or co-payments are due at the time of the visit. Returned checks will be charges a $25 fee. You are encouraged and are responsible to schedule sessions as you feel will be helpful. I will recommend a schedule that I believe will be most beneficial for your goals.
2. **No-Show/Late Cancel:** If you are unable to attend your scheduled appointment, **you must call 48 hours in advance, or you will be charged a $150 No-Show/Late Cancel Fee.** This is the client's responsibility as insurance will not cover this.
3. **Insurance Benefits:** My office does call and check on Outpatient Mental Health Benefits. This is not a guarantee of coverage/payment, and the insurance companies do state this before benefits are given. You are ultimately responsible for payment of professional services rendered regardless of insurance coverage.
4. **Other Fees:** Most fees are billed at $150/hour in 15-minute increments. **Client phone calls:** Free for the first 10 minutes and then pro-rated at $150/hour. **All other phone calls and services** (i.e., consultation with a psychiatrist, reading extensive emails) charged at $150/hour. **Legal:** Any work related to legal situation (i.e., attorney calls, writing reports, making copies, court appearances) ***will be billed at $300/hour*** (billed in 15-minute increments). **Refund:** If a client is due a refund, this will be provided by check or credit within 5 business days of therapist becoming aware of refund amount due.

Therapist Availability & Emergency Procedures

1. This practice does **NOT** have the capacity to respond to counseling emergencies. Emergencies should be directed to 911 or to the local **24-hour crisis line at (480) 784-1500**. If your child has a psychiatrist, you should also contact him/her in times of emergent need.
2. You may leave a message at any time on my **confidential voicemail at (480) 861-9624.** I check messages frequently throughout the day and will return your call as soon as I am ale. On weekends and holidays, I check my messages less frequently and may only respond to urgent calls. Non-urgent phone calls are generally returned within 48 hours. If I haven't returned your call within 48 hours, please call again.
3. Email and text communication is for non-emergencies only. It may be used for appointment changes, referrals and non-clinical questions. I check emails as often as possible, but if you are canceling an appointment with less than 48 hours notice, please call the number listed above. I have no way to

guarantee the confidentiality of electronic communication so please use at your own discretion. All non-routine emails/texts will be printed out and kept as part of your permanent record.

Confidentiality (*Please refer to HIPAA Notice for additional information).*
The confidentiality of all counseling interactions is protected by law. Anything you tell me is considered privileged information and will be held in confidence by me. I will not release any information to others about you unless you give me explicit permission to do so in writing, by signing a release of information form. There are certain situations in which, as a therapist, I am mandated by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, I am not required by law to inform you of my action in this regard. These circumstances include: medical emergencies, the existence of a threat of danger to self or others, reasonable suspicion of current child abuse, abandonment or neglect, dependent adult or elder abuse, a court order, third party billing claims requirements, receipt of properly executed consent form, and where otherwise legally required (such as to comply with worker compensation laws, or to comply with the USA Patriot Act. The HIPAA Notice of Privacy Practices, on the website and available on request, details the considerations regarding confidentiality, privacy, and your records. This packet also contains information about the right to access your records and the details of the procedures to obtain them, should you choose to do so. Periodically, the HIPAA Notice may be revised. Any changes to these privacy practices can be found online at www.hhs.gov.

Parents are encouraged to respect their minor child's right to confidentiality. Parents can be assured that the minor will be encouraged to share critical information and that the parents will be given information regarding therapy themes and treatment progress.

Ms. Wiskerchen is conducting some treatment via telehealth. She most likely will use Sessions (HIPAA compliant) phone, ZOOM or FaceTime for client contact. If you request FaceTime or Zoom, your signature indicates your agreement with this form of contact which may not be HIPAA compliant.

_____**(*Initial*)** I have been informed of the limitations of confidentiality in terms of the treatment of a minor. I understand that special care and sensitivity may be required in releasing information to me about certain topics such as substance abuse and sexual activity. I accept Linda Wiskerchen's judgment regarding releasing information related to the treatment of this minor. In addition, I understand that if Linda Wiskerchen believes this minor is in danger of hurting him/herself, I will be notified immediately. In any custodial arrangement, both parents have the right to contact the therapist and inquire regarding their child's treatment progress (unless otherwise indicated by the courts.

In the event of my death or incapacity, the records for my clients that are actively receiving services (seen within the past month) will be given to one or more local behavioral health professionals to facilitate continuation of treatment. In such a situation, you have the right to continue treatment with this professional, discontinue treatment, or ask for a referral. Records for my inactive clients will be handled by a "records custodian," which may be an individual or company. The custodian will be responsible for satisfying record requests and destroying records when legal timeframes for records retention are satisfied.

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Emails, Cell Phones, and Faxes

Individual may choose to contact me via email or cell phone. In doing so, they agree to the understanding that email and cell phone communication are not guaranteed confidential methods of communication, and they are, by choice, relinquishing their rights of confidentiality. Please notify me if you decide to avoid or limit, in any way, the use of any or all communication devices, such as email, cell phone/texts or faxes. If you communicate confidential or highly private information via electronic media, I will assume that you have made an informed decision and will view it as your agreement to take the risk that such communication may be intercepted.

Social Media

I do not accept friend/contact requests from current or former clients on any social networking site. I believe that adding clients as contacts can compromise yur confidentiality and may also blue the boundaries of our therapeutic relationship. My primary concern is your privacy. Please note that I do not follow current or former clients on blogs or Twitter, etc. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together.

Legal Disputes

_____**(*Initial*)** I understand that this therapist is not conducting a custody or visitation evaluation for my child. I agree not to involve the therapist in any custody or visitation disputes as I understand that would not be in the best interest of my child's relationship with the therapist and would be counterproductive to the therapeutic process. I agree not to involve the therapist in court proceeding s regarding any treatment of my child now or in the future, nor will the therapist be asked to share my child's records regarding any such proceeding.

_____**(*Initial*)** I authorize evaluation and treatment from Linda Wiskerchen, LCSW, RPT-S, for myself and/or the child/children for whom I am legally responsible, and I agree to pay all fees for such treatment. I acknowledge that I have access to a copy of this informed consent agreement and the HIPAA Notice of Privacy Practices (**upon request**)**.** It is agreed that either of us may discontinue treatment at any time. I also authorize the release of my/our DSM-5-TR diagnoses code, at my request, to be printed on a Claim and/or Superbill form to submit to insurance for possible benefits.

Please SIGN and PRINT your name below:

Parent: _____ _____ Date: _____

Parent: _____ _____ Date: _____

Minor: _____ _____ Date: _____

Therapist: Linda Wiskerchen, LCSW, RPT-S Linda Wiskerchen, LCSW, RPT-S Date: _____

NOTICE OF PRIVACY PRACTICES for Protected Health Information (PHI)

This notice provides you with information about how your protected health information (PHI) may be used and disclosed by this provider, as well as your rights regarding your PHI, including how to access this information. Your PHI includes any identifiable health information, which relates to your past, present or future health, treatment or payment for health care services. I am a licensed therapist, licensed by the State of Arizona through the BBHE. I create and maintain treatment records that contain individually identifiable health information about you. This notice concerns the privacy and confidentiality of those records and the information contained therein. **EFFECTIVE DATE OF THIS NOTICE.** This notice first became effective June 1, 2008.

The Health Insurance Portability and Accountability Act (HIPAA) requires me to:

- Maintain the privacy and confidentiality of your PHI as required by law;
- Provide you with a notice as to my legal duties, privacy practices and your rights regarding your medical information.
- Follow the terms of the current notice
- Notify you if I cannot accommodate a requested restriction or request and
- Accommodate reasonable requests regarding methods to communicate health information with you.

I reserve the right to:

- Amend, change or eliminate provisions in my privacy practices and to enact new provisions regarding the PHI I maintain, provided that the changes are permitted by law. If my information practices change, I will amend this Notice.
- Before an important change is made in my privacy practices, I will change this notice, post the revised notice in a clear and prominent location and make the new notice available upon request.

Federal privacy rules allow health care providers (me) who have a direct relationship with a patient (you) to use or disclose the patient's PHI without the patient's written authorizations, to carry out the health care provider's own treatment, payment or health care operations.

FOR TREATMENT: If I decide to consult with another licensed health care provider about your condition, I would be permitted to use and disclose your PHI, which is otherwise confidential, in order to assist me in the diagnosis or treatment of your mental health condition. The word "treatment" includes, among other things, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

FOR PAYMENT: I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. I may also provide PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims. If your health plan requests a copy of your health records, or a portion thereof, in order to determine whether or not payment is warranted under the terms of your policy, I am permitted to disclose your PHI.

FOR HEALTH CARE OPERATIONS: If your health plan decides to audit my practice to review my competence, your mental health records may be used or disclosed for those purposes.

ADDITIONAL USES AND DISCLOSURES that do NOT require your consent:

- ***Appointment reminders and health related benefits or services:*** We may contact you by leaving you a voicemail or sending an email to provide appointment reminders or to give you information about treatment alternatives, or other health care services or benefits that we offer.
- ***Workers compensation:*** If you are seeking compensation through Workers Compensation, we may disclose your health information to the extent necessary to comply with laws relating to workers' compensation.
- ***Court Order:*** If disclosure is compelled by a court pursuant to an order of the court.
- ***Adjudication:*** If disclosure is compelled by a board, commission or administrative agency for purposes of adjudication pursuant to its lawful authority.
- ***Abuse/Neglect:*** We may disclose your health information to public authorities as allowed/required by law to report suspected abuse or neglect of a child, elder or dependant adult.
- ***To avoid harm:*** To avert a serious threat to your own health or safety or the health or safety of others, we may disclose your PHI consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.
- ***When disclosure is required by federal, state or local law, judicial or administrative proceedings or law enforcement.*** For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.

- ***For health oversight activities***. For example, I may have to report information to assist the government when it conducts an investigation or inspection of a health provider or organization. The Board of Behavioral Health Examiners, who license Clinical Social Workers, is an example of a health oversight agency.
- ***Compliance***: If disclosure is compelled by the U.S. Secretary of Health and Human Services to investigate or determine my compliance with privacy requirements under the federal regulations (the "Privacy Rule.")
- ***Other:*** If disclosure is specifically required by law.
- ***Please note***: The above list is not an exhaustive list but informs you of most circumstances when disclosure without your written authorization may be made. Other uses and disclosures will generally (but not always) be made only with your written authorization.
- I will not disclose your PHI for any purpose not listed above without your specific written authorization. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization).

- ***You have the right to request restrictions on certain uses and disclosure of your PHI, such as those necessary to carry out treatment, payment or health care operations.*** *I am not required to agree to your requested restriction. If I do agree, I will maintain a written record of the agreed upon restriction* and abide by them except in emergency situations.
- ***You have the right to receive confidential communications of PHI from me by alternative means or at alternative locations*** *for example, sending mail to an* alternate address or to an e-mail instead of regular mail). I will agree to your request so long as it is reasonable for me to do so.
- ***You have the right to inspect and copy PHI by making a specific request to do so in writing.*** However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes or PHI I collect in connection with a legal proceeding. I will respond to you within 10 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more that $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.
- **The *Right to Get a List of the Disclosures I have made***. You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to such as those named for treatment, payment, or health care operations directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel or disclosures made before June 1, 2008.
- ***The Right to Amend Your PHI.*** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 30 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (a) Correct and complete, (b) not created by me, (c) not allowed to be disclosed, and/or (d) not a part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it and tell others that need to know about the change to your PHI.

If you want to exercise any of the above rights, please contact the Privacy Officer, Linda Wiskerchen, at (480) 861-9624. She will provide you with assistance on the steps to take to exercise your rights.

QUESTIONS/COMPLAINTS: If you have questions, would like additional information or want to report a problem regarding the handling of your information, you may contact the Privacy Officer Linda Wiskerchen at (602) 861-9624. Additionally , if you believe your privacy rights have been violated, you may file a written complaint with the Secretary of the Department of Health and Human Services. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

I have read and received a copy of the HIPAA NOTICE OF PRIVACY PRACTICES, and have had my questions about privacy and confidentiality answered to my satisfaction. I understand the terms of this HIPAA Notice.

Signature _____ Date _____

Signature _____ Date _____