Patient Record Update

Patient Information

Name:_____ SSN:_____

Add1:_____ DOB:_____

Add2:_____ Home Phone:_____

City:_____ Work Phone:_____

State:_____ Zip:_____ Cell Phone:_____

Guarantor Information - if different from self

Name:_____ SSN:_____

Add1:_____ DOB:_____

Add2:_____ Home Phone:_____

City:_____ Work Phone:_____

State:_____ Zip:_____ Relationship:_____

Employer Information

Name:_____ Occupation:_____

Add1:_____

City:_____

State:_____ Zip:_____

Insurance Information: Please provide copies of cards to the receptionist

Primary Insurance Information

Plan Name:_____ Policy#:_____

Cardholder:_____ DOB:_____

Relationship to patient: (circle one) __Self__Spouse__Parent__Other____ SSN:_____

Have you contacted your insurance regarding your Mental Health benefits?_____

If yes, what are they?_____

Insurance Information: Please provide copies of cards to the receptionist

Secondary Insurance Information

Plan Name:_____ Policy#:_____

Cardholder:_____ DOB:_____

Relationship to patient: (circle one) __Self__Spouse__Parent__Other____ SSN:_____

Have you contacted your insurance regarding your Mental Health benefits?_____

If yes, what are they?_____

Pharmacy Name:_____ Pharmacy Phone Number:_____

Address:_____

City:_____ State:_____ Zip:_____

Signature: Date:

FINANCIAL POLICY

Thank you for choosing our doctors and therapists to meet your needs. The following is a statement of our Financial Policy, which we ask you to read and sign prior to treatment.

Psychiatric and psychological services have already been handled differently by insurance companies than medical/surgical services; therefore we ask you to become as knowledgeable as possible about your particular insurance plan.

YOUR PORTION OF PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, DISCOVER, AND MASTERCARD.

MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to_____ _____ for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

INSURANCE

Your insurance policy is a contract between you and your insurance company. If you have given us all the required information, we can submit the mental health services to the insurance companies with which we participate. We must have current policy, group, ID, and claim numbers. We will make a copy of your insurance card. Please be aware that some services may be "non-covered" services according to your policy. You are still responsible for payment of these services.

Many of us are members of "provider panels" of certain companies. If this is true for your insurance, then part of the payment will come directly to us from the company. You will need to pay a "co-payment" at each visit, the amount of which is determined by *your insurance company* (not be us). You will need to call your insurance carrier to learn what you co-payment will be. You may also need to be in touch with them from time to time in order to make sure that your claims are being paid and that your coverage is still authorized for our services.

If you are covered by an insurance carrier that requires precertification, it is your responsibility to call the company for authorization prior to your first appointment. If you do not have authorization, you will be billed for the services.

We accept the approved amount for some major insurance companies and some HMO and PPO programs, however please have the employer name, claim number, and address of where the claim should be sent. We require written preauthorization from the insurance carrier for all auto insurance and Workers' Compensation cases.

Please note we do not participate in Medical Assistance.

COMMERCIAL INSURANCE

I hereby authorize the release of information necessary to file a claim with my insurance company and *assign benefits otherwise payable to me to the physician indicated on the claim.*

I understand that I am financially responsible for any balance not covered by my insurance carrier.

A copy of this signature is as valid as the original.

Signature_____ Date_____

MINOR PATIENTS (UNDER 18 YEARS OF AGE)

The parent/guardian/adult accompanying a minor child is responsible for full payment. If both parents have insurance, the parent with the first birthday in the year is most often the primary insurer. Please check your insurance policy to determine which company is primary before your appointment. In divorce cases, we will bill our participating insurances, but the parent who brings the child in for services is ultimately the responsibility party.

FORENSIC EVALUATIONS

Forensic Evaluations are usually not covered by insurance and are paid in full prior to the evaluation unless alternative arrangements are made.

BILLING

A Billing statement covering your services will be mailed to you each month. We expect payment to be made on a timely basis. A past due account will be turned over to our collection agency if no payment has been made.

I have read, understand, and agree to this Financial Policy.

_____ _____

Signature of Patient of Responsible Party Date

DGR BEHAVIORAL HEALTH ELECTRONIC COMMUNICATIONS POLICY

E-mail is only for scheduling or for a clinical reason that we can discuss ahead of time.

E-mail is not a substitute for discussions that should take place face-to-face.

E-mails should never be used for emergencies.

Do not e-mail your provider if you expect a quick response, as we only check e-mail occasionally.

We do not follow patients' blogs, follow patients on Twitter, Google them, friend them, or communicate by texting.

Cell phones should be off (or in silent mode) during sessions. Secret recording of sessions is not permitted.

To protect your privacy and respect that of others, please do not have cell phone conversations in the waiting room.

Form 28 Couple's Information Form

1. Name: _____ 2. Age: _____ 3. Date: _____

4. Address: _____ City: _____ State: _____ Zip: _____

5. Briefly, what is your main purpose in coming to couple's counseling? _____

_____

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. Your answers will help plan a course of couple's therapy that is most suitable for you and your partner. Do not exchange this information with your partner at this time.

Several of your answers on this form may be shared later with your partner during joint therapy sessions if you give us permission to share this information. For this reason you are advised to respond honestly and carefully to each item. If certain questions do not apply to you or you do not want to share this information, please leave them blank.

6. Have you been married before? ___ Yes ____ No
   If Yes, how many previous marriages have you had? 1 2 3 4 5+
7. How long have you and your partner been in this relationship? ___
8. Are you and your partner presently living together? ___ Yes ___ No
9. Are you and your partner engaged to be married? ___ Yes When? _____ _____ No
10. Fill out the following information for each child of whom the natural parent is both you and your partner, children from previous relationships, and adopted children.
    ___ Neither of us has children (go to next page) ___ One or each of us has children (continue)

*"Whose child?" answering options:
B = Both of ours, natural child
BA = Both of ours, adopted (or taken on)
M = My natural child
MA = My child, adopted (or taken on)
P = Partner's natural child
PA = Partner's child, adopted (or taken on)

Child's name	Age	Sex	*Whose child?	Lives with whom
(1) _____	_____	F M	_____	___ Yes ___ No
(2) _____	_____	F M	_____	___ Yes ___ No
(3) _____	_____	F M	_____	___ Yes ___ No
(4) _____	_____	F M	_____	___ Yes ___ No
(5) _____	_____	F M	_____	___ Yes ___ No
(6) _____	_____	F M	_____	___ Yes ___ No
(7) _____	_____	F M	_____	___ Yes ___ No
(8) _____	_____	F M	_____	___ Yes ___ No

11. List five qualities that initially attracted you to your partner:

Does your partner still possess this trait?

(1) _____ ____ Yes ____ No

(2) _____ ____ Yes ____ No

(3) _____ ____ Yes ____ No

(4) _____ ____ Yes ____ No

(5) _____ ____ Yes ____ No

12. List four negative concerns that you initially had in the relationship:

Does your partner still possess this trait?

(1) _____ ____ Yes ____ No

(2) _____ ____ Yes ____ No

(3) _____ ____ Yes ____ No

(4) _____ ____ Yes ____ No

13. List five present positive attributes of your partner:

Do you often praise your partner for this trait?

(1) _____ ____ Yes ____ No

(2) _____ ____ Yes ____ No

(3) _____ ____ Yes ____ No

(4) _____ ____ Yes ____ No

(5) _____ ____ Yes ____ No

14. List five present negative attributes of your partner:

Do you nag your partner about this trait?

(1) _____ ____ Yes ____ No

(2) _____ ____ Yes ____ No

(3) _____ ____ Yes ____ No

(4) _____ ____ Yes ____ No

(5) _____ ____ Yes ____ No

15. List five things you do (or could do) to make the marriage more fulfilling for your partner:

Do you often implement this behavior?

(1) _____ ____ Yes ____ No

(2) _____ ____ Yes ____ No

(3) _____ ____ Yes ____ No

(4) _____ ____ Yes ____ No

(5) _____ ____ Yes ____ No

16. List five things that your partner does (or could do) to make the marriage more fulfilling for you:

Does your partner often implement this behavior?

(1) _____ ____ Yes ____ No

(2) _____ ____ Yes ____ No

(3) _____ ____ Yes ____ No

(4) _____ ____ Yes ____ No

(5) _____ ____ Yes ____ No

17. List five expectations or dreams you had about relationships before you met your partner:

Has this been fulfilled?

(1) _____ ____ Yes ____ No

(2) _____ ____ Yes ____ No

(3) _____ ____ Yes ____ No

(4) _____ ____ Yes ____ No

(5) _____ ____ Yes ____ No

18. On a scale of 1 to 5, rate the following items as they pertain to:
(1) The present state of the relationship
(2) Your need or desire for it
(3) Your partner's need or desire for it

Circle the Appropriate Response for Each (If not applicable, leave blank.)

	Present state of the relationship Poor Great	Your need or desire Low High	Partner need or desire Low High
(1) Affection	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
(2) Childrearing rules	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
(3) Commitment together	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
(4) Communication	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
(5) Emotional closeness	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
(6) Financial security	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
(7) Honesty	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
(8) Housework sharing	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
(9) Love	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
(10) Physical attraction	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
(11) Religious commitment	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
(12) Respect	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
(13) Sexual fulfillment	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
(14) Social life together	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
(15) Time together	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
(16) Trust	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Other (specify)			
(17) _____	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
(18) _____	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
(19) _____	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
(20) _____	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

19. For couples living together. Which partner spends more time conducting the following activities?

Circle the Appropriate Response for Each (If not applicable, leave blank.)

(M = Me P = Partner E = Equal time)

	Is this equitable (fair)?		Comments
(1) Auto repairs	M P E	___ Yes ___ No	_____
(2) Child care	M P E	___ Yes ___ No	_____
(3) Child discipline	M P E	___ Yes ___ No	_____
(4) Cleaning bathrooms	M P E	___ Yes ___ No	_____
(5) Cooking	M P E	___ Yes ___ No	_____
(6) Employment	M P E	___ Yes ___ No	_____
(7) Grocery shopping	M P E	___ Yes ___ No	_____
(8) House cleaning	M P E	___ Yes ___ No	_____
(9) Inside repairs	M P E	___ Yes ___ No	_____
(10) Laundry	M P E	___ Yes ___ No	_____
(11) Making bed	M P E	___ Yes ___ No	_____
(12) Outside repairs	M P E	___ Yes ___ No	_____
(13) Recreational events	M P E	___ Yes ___ No	_____
(14) Social activities	M P E	___ Yes ___ No	_____
(15) Sweeping kitchen	M P E	___ Yes ___ No	_____
(16) Taking out garbage	M P E	___ Yes ___ No	_____
(17) Washing dishes	M P E	___ Yes ___ No	_____
(18) Yard work	M P E	___ Yes ___ No	_____
(19) Other: _____	M P E	___ Yes ___ No	_____
(20) Other: _____	M P E	___ Yes ___ No	_____

20. If some of the following behaviors take place only during MILD arguments, circle an "M" in the appropriate blanks. If they take place only during SEVERE arguments, circle an "S." If they take place during ALL arguments, circle an "A." Fill this out for you and your impression of your partner. If certain behaviors do not take place, leave them blank.

Circle the Appropriate Response for Each

(M = Mild arguments only S = Severe arguments only A = All arguments)

Behavior	By me	By partner	Should this change?
(1) Apologize	M S A	M S A	___ Yes ___ No
(2) Become silent	M S A	M S A	___ Yes ___ No
(3) Bring up the past	M S A	M S A	___ Yes ___ No
(4) Criticize	M S A	M S A	___ Yes ___ No

(5) Cruel accusations	M S A	M S A	___Yes ___No
(6) Cry	M S A	M S A	___Yes ___No
(7) Destroy property	M S A	M S A	___Yes ___No
(8) Leave the house	M S A	M S A	___Yes ___No
(9) Make peace	M S A	M S A	___Yes ___No
(10) Moodiness	M S A	M S A	___Yes ___No
(11) Not listen	M S A	M S A	___Yes ___No
(12) Physical abuse	M S A	M S A	___Yes ___No
(13) Physical threats	M S A	M S A	___Yes ___No
(14) Sarcasm	M S A	M S A	___Yes ___No
(15) Scream	M S A	M S A	___Yes ___No
(16) Slam doors	M S A	M S A	___Yes ___No
(17) Speak irrationally	M S A	M S A	___Yes ___No
(18) Speak rationally	M S A	M S A	___Yes ___No
(19) Sulk	M S A	M S A	___Yes ___No
(20) Swear	M S A	M S A	___Yes ___No
(21) Threaten breaking up	M S A	M S A	___Yes ___No
(22) Threaten to take kids	M S A	M S A	___Yes ___No
(23) Throw things	M S A	M S A	___Yes ___No
(24) Verbal abuse	M S A	M S A	___Yes ___No
(25) Yell	M S A	M S A	___Yes ___No
(26) _____	M S A	M S A	___Yes ___No
(27) _____	M S A	M S A	___Yes ___No
(28) _____	M S A	M S A	___Yes ___No

21. How often do you have: Mild arguments? _____

Severe arguments? _____

22. When a MILD argument is over how do you usually feel?

Check Appropriate Responses

___ Angry
___ Anxious
___ Childish
___ Defeated
___ Depressed
___ Guilty
___ Happy
___ Hopeless
___ Irritable
___ Lonely
___ Nauseous
___ Numb
___ Regretful
___ Relieved
___ Stupid
___ Victimized
___ Worthless

23. When a SEVERE argument is over how do you usually feel?

Check Appropriate Responses

___ Angry
___ Anxious
___ Childish
___ Defeated
___ Depressed
___ Guilty
___ Happy
___ Hopeless
___ Irritable
___ Lonely
___ Nauseous
___ Numb
___ Regretful
___ Relieved
___ Stupid
___ Victimized
___ Worthless

24. Which of the following issues or behaviors of you and/or your partner may be attributable to your relationship or personal conflicts? If an item does not apply, leave it blank.

Circle the Appropriate Responses

(M = My behavior P = Partner's behavior B = Both)

Alcohol consumption	M	P	B	Perfectionist	M	P	B
Childishness	M	P	B	Possessive	M	P	B
Controlling	M	P	B	Spends too much	M	P	B
Defensiveness	M	P	B	Steals	M	P	B
Degrading	M	P	B	Stubbornness	M	P	B
Demanding	M	P	B	Uncaring	M	P	B
Drugs	M	P	B	Unstable	M	P	B
Flirts with others	M	P	B	Violent	M	P	B
Gambling	M	P	B	Withdrawn	M	P	B
Irresponsibility	M	P	B	Works too much	M	P	B
Lies	M	P	B	Other (specify)			
Past marriage(s)/relationship(s)	M	P	B	_____	M	P	B
Other's advice	M	P	B	_____	M	P	B
Outside interests	M	P	B	_____	M	P	B
Past failures	M	P	B	_____	M	P	B

25. In the remaining space, please provide additional information that would be helpful:

_____

_____

_____

I, _____, hereby give my permission for this clinic to share the information that I provide on this form with _____ (partner) when it is deemed appropriate by an agreement between me, my partner, and our therapist. This sharing of information may take place only during a joint counseling session (both partners present).

Client's signature: _____ Date: ___/___/___

PLEASE RETURN THIS AND OTHER ASSESSMENT MATERIALS TO THIS OFFICE AT LEAST TWO DAYS BEFORE YOUR NEXT APPOINTMENT.

DGR Behavioral Health, LLC
2201 Ridgewood Road, Suite 400
Wyomissing, PA 19610
Telephone (610) 378-9601
Fax (610-378-9061

PENNSYLVANIA NOTICE FORM

Notice of Provider's Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may *use* or *disclose* your *protected health information* (PHI), for *treatment, payment, and health care operations* purposes with your *consent.* To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health care record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  - *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would when we consult with another health care provider, such as your family physician or another provider.
  - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- *"Use"* applies only to activities within our practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of our practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Use and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment, and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection that PHI. (Please see Section VI for further explanation.) We will also obtain an authorization from you before using or disclosing PHI in a way that is not described in this notice.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have reasonable cause, on the basis of our professional judgment, to suspect abuse of children with whom we come into contact in our professional capacity, we are required by law to report this to the Pennsylvania Department of Public Welfare.

- **Adult and Domestic Abuse:** If we have reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), we may report such to the local agency which provides protective services.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services we provided you or the records thereof, such information is privileged under state law, and we will not release the information without your written consent, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** If you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people, and we determine that you are likely to carry out the threat, we must take reasonable

measures to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.

- **Worker's Compensation:** If you file a worker's compensation claim, we will be required to file periodic reports with your employer which shall include, where pertinent, history, diagnosis, treatment, and prognosis.

- **Coroner's and Funeral Directors:** We may disclose health information about you to a coroner if that information is pertinent to the coroner's duties, such as identifying a decedent or determining the cause of death. We may also disclose health information to funeral directors to enable them to carry out their duties.

- **Food and Drug Administration (FDA):** We may disclose health information about you to the FDA or to an entity regulated by the FDA, in order, for example, to report an adverse event or a defect related to a drug you are taking or a medical device you are using. Medical devices are rarely used in psychiatry but medications are.

- When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Provider's Duties

Patient's Rights:

- *Right to Request Restrictions* – you have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect and obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in your record. We may deny access to your PHI in under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

- *Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket* – You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

- *Right to Be Notified if There is a Breach of Your Unsecured PHI* – You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Provider's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise the policies and procedures, we will post the revision in our waiting rooms, and you may request a copy from our Privacy Officer.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the following person: Privacy Officer, DGR Behavioral Health, LLC, Wyomissing, PA 19610; phone: 610-378-9601.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Psychotherapy Notes

In the course of your care with us, you may receive treatment from a mental health professional (such as a psychiatrist) who keeps separate notes documenting or analyzing the contents of conversations during a private counseling session or a group, joint, or family counseling session. These notes, known as "psychotherapy notes," are kept apart from the rest of your medical record and typically do not include basic information such as your medication treatment record, counseling session start and stop times, the types and frequencies of treatment you receive, or your test results. Summaries of your diagnosis, condition, treatment plan, symptoms, prognosis, or treatment progress, although they may be contained within those psychotherapy notes, typically are not protected as psychotherapy notes when they appear in other sections of your records.

We will not disclose psychotherapy notes to others unless you have given written authorization to do so, subject to narrow exceptions (e.g. to prevent harm to yourself or others and to report child abuse/neglect.). You cannot be required to authorize the release of your psychotherapy notes in order to obtain health-insurance benefits for your treatment or to enroll in a health plan. If you have any questions, feel free to discuss this subject with your therapist.

Please note that we may deny you access to psychotherapy notes if we determine that disclosure of specific information will constitute a substantial detriment to your treatment; or we will reveal the identify of persons or breach the trust or confidentiality of persons who have provided information upon an agreement to maintain their confidentiality. In very limited circumstances we may also deny you access to other portions of the records. These circumstances include when information was obtained from others under a promise of confidentiality and access would likely reveal the source of the information; and when we determine that access is reasonably likely to endanger the life or physical safety of either you or another person.

VII. Effective Date of Privacy Policy

This notice will go into effect on October 1, 2013.

DGR Behavioral Health, LLC
2201 Ridgewood Road, Suite 400
Wyomissing, PA 19610
Telephone (610) 378-9601
Fax (610) 378-9061

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: _____

Birth Date: _____

Maiden or other name (if applicable):

_____

I acknowledge that I have received a copy of the Notice of Privacy Practices of DGR Behavioral Health, LLC, effective October 1, 2013.

Signature (patient or authorized representative):

_____

Date:

_____

Relationship/authority
(if signed by authorized representative):

_____

Consent to use and disclose your health information

This form is an agreement between you, _____ and DGR Behavioral Health. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____.

When we examine, 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 here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

_____ _____

Signature of client or his or her personal representative Date

_____ _____

Printed name of client or personal representative Relationship to the client

_____

Description of personal representative's authority

CANCELLATION POLICY

We consider an appointment to be a commitment and an agreement. When an appointment is scheduled, the time is set-aside for you and no one else. Consequently, unlike other doctors' offices, we do not double or triple book patients. However, in order to do this, we must charge a fee for all appointments not cancelled within 24 hours of the appointment. If your appointment falls on a Monday, you may leave a message with the answering service over the preceding weekend.

Cancelled Appointments:	No charge will be made for any appointment cancelled with at least 24 hours advance notice.
Missed Appointments:	An appointment cancelled on less than a 24-hour notice, or an appointment missed without a notice of cancellation, will be billed a cancellation fee. This fee will not be charged to insurance, and is your responsibility to pay in full.
Exception:	Same-day cancellations because of serious medical/family emergencies or dangerous road conditions (snow and ice) will not be charged, as long as a telephone call is received in the office before the scheduled appointment time.

We will try to give you a reminder call if you have requested one. However, you are responsible for the appointment whether or not you receive that call.

I am aware of the cancellation policy and agree to the terms.

_____ _____

Signature Date

_____

Parent Signature if appropriate