Gardenia Cove
MENTAL HEALTH, P.C.

OFFICE POLICIES AND PROCEDURES

At Gardenia Cove, we strive to provide evidence-based, compassionate, holistic and patient-focused professional mental health services in an inviting and accepting environment which promotes overall psychological wellness. In order to best serve our patients, we follow certain policies and procedures.

Patient Rights and Responsibilities

I have a right to privacy and confidentiality. All records and communications will be treated confidentially and in compliance with applicable state and federal laws. These laws may obligate my provider or insurance carrier/managed care company to report suspected abuse or neglect, domestic violence, and those who pose a danger to themselves or others. In these cases, I, the patient, understand that without a Release of Information on file, my care may not be discussed with anyone (family, spouse, other medical providers, etc.). I understand that in order for my insurance or managed care company to pay for services my provider must submit to the company a diagnosis which describes a mental disorder of which I or my loved one suffers. This information is often stored in a medical information data bank that other insurance companies may access when I apply for insurance. I realize that if I do not wish to release this information, I must pay out-of-pocket the full cost of my services at the time they are provided.

My health is my responsibility. I will contact an emergency provider, as well as my treatment provider, for any and all serious situations that arise, even if after normal office hours. I will work with my provider to achieve my treatment goals and will advise my treatment provider of changes in my condition. I give authorization for Gardenia Cove to access my prescription drug history in order to provide complete and thorough treatment. I understand that I can terminate treatment at any time.

Privacy Policy

My health information, including health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity, and similar types of health-related information, created and received by this office in written, electronic, or spoken word may be used and disclosed for treatment purposes, to coordinate my care, for payment purposes, for health care operations, to coordinate my health plan or insurance coverage, to remind me of my appointments, to suggest treatment alternatives, to offer health related products and services, to advert a serious threat to health or safety, to comply with the law and law enforcement officials, for research purposes were permitted and appropriate, to comply with military or government authorities, for workers' compensation purposes, for lawsuit purposes in response to court or administrative orders, to friends and family per my request and permission, or in cases of incapacity. A full list of patient rights and responsibilities can be found on our website on the Privacy Practices Page.

Prescription Refill Request

It is my responsibility to ensure I have an adequate supply of medications. Prescription refills must be requested three (3) business days before the medication will run out. Prescriptions will not be filled after hours or over the weekend. Refill requests received on Fridays may not be completed until the following week. It is my responsibility to notify the office in a timely manner when refills are necessary.

It is important to keep my scheduled appointments to ensure that I receive timely refills. Repeated no-shows or cancellations will result in a denial of refills. All prescriptions require a follow up appointment at least every three months, or more frequently as deemed necessary by the prescribing provider. I understand that attending regularly scheduled appointments is necessary for refills as it is essential that I am evaluated to ensure proper medication management. Should a refill be necessary, a charge for staff time may be incurred. New symptoms or events require an office visit. I understand that I will not be diagnosed or treated over the phone. Medication changes will not be made over the phone, an acute visit is necessary

to provide appropriate care. I understand it is my responsibility to know what my health insurance plan will and will not cover. If my insurance company asks me to use a mail-order pharmacy for medications, I will contact the mail-order pharmacy and have them fax over the necessary forms. RefillIs can only be authorized on medications prescribed by providers from our office. We will not refill medications that are not for the primary purposes of mental health treatment.

Medical Records

All requests for medical records must be requested in writing and approved by me except in cases where the law requires them to be released. There may be a charge for records to be faxed, printed, or distributed. Please allow up to 14 days for medical record requests to be processed. As a patient I have certain rights to my medical and related billing records. A full list of patient rights and information about how to request information or file a complaint is documented on the Gardenia Cove website on the Privacy Practices page.

Answering Service

Please call our office with any questions or concerns Monday-Thursday from 8:00am-12:00pm and 1:00pm-4:30pm and Friday from 8:00am-12:00pm. For any urgent matters after hours or on the weekend, please call our office number and you will be connected with an answering service. If after hour calls are greater than 10 minutes or if continuous non-urgent calls are made after hours, a fee may be applied to patient account. This fee is not covered by insurance. Always call 911 or go to the nearest emergency room in the event of an emergency.

No-Shows, Late Cancellations, and Late Arrivals

In order to provide quality psychiatric services while also maintaining a practice, appropriate scheduling is extremely important. In an effort to ensure that everyone receives the highest quality of care, Gardenia Cove avoids overbooking appointments as much as possible. For this reason, the following policy is in place.

I understand that cancellation of a scheduled appointment should be avoided if possible. If I cannot make my appointment, I must cancel within 24 business hours (weekends and holidays are not included in the 24-hour period), in order to avoid a no-show or late cancellation charge.

I understand that if I no-show for an appointment, or do not notify the office of a cancellation at least 24 business hours in advance, I will be charged $100 for physician and therapist appointments.

I understand that if I am late for an appointment, my provider will try to squeeze me into the schedule if possible. There may be a significant wait in this instance. If I am over 10 minutes late to a physician appointment and unable to wait or there is no way to squeeze me in, I will be charged $100 for the missed appointment. If I am over 35 minutes late to a therapy appointment and unable to wait or there is no way to squeeze me in, I will be charged $100 for the missed appointment.

I understand that my insurance company will not cover these charges. I understand that I will not be allowed to schedule another appointment with my provider until this is paid-in-full.

I understand that after two consecutive no-shows or late cancellations, or three no-shows or late cancellations within a 12-month period, I may no longer be able to schedule with my provider.

Controlled Substances

Controlled substances have a high rate of abuse due to their addictive properties. They, just like all medications, should be taken exactly as they are prescribed. I understand that any significant violation of this policy will be grounds for dismissal.

1. The purpose of treatment is to improve the quality of life and functional ability of the individual. Medications will be adjusted as necessary to meet these goals.
2. I will inform the office of any new medications, medical conditions, or adverse effects of my medications.
3. I will inform all healthcare providers of the controlled substances I am taking.
4. I understand that there will be no refills on controlled substances before they are due. If any medications are needed before refills are due, a taper dose may be given to decrease risk of withdrawal if needed for that medication.
5. It is my responsibility to safe guard my prescriptions and medications. They will not be replaced if lost, damaged, or stolen.
6. Controlled substances cannot be refilled over the phone. An appointment is necessary to receive a refill. If an appointment must be cancelled, Gardenia Cove will do their best to accommodate me with another appointment to prevent a lapse in treatment. However, I understand that I will need to call the office if I am nearing the end of my prescription.
7. Each controlled substances should only be actively prescribed by one prescriber.
8. If I am prescribed a controlled substance, I may be asked to have a random drug screen as well as a baseline drug screen as these medications can have severe adverse effects when combined with other substances.
9. Gardenia Cove participates in PDMP, a statewide tracking system pertaining to all controlled substances.

Financial

All co-pays and deductibles are expected at the time of service. If full payment cannot be made at the time of service, a $25 late fee will be added to my account. If I do not pay or set up a payment plan with the practice within 30 days, my credit card on file will be charged. As a courtesy, I will be notified by Gardenia Cove via email or phone that this will take place. If my account remains delinquent, management can determine that the practice will refuse to provide services to me until my balance is paid-in-full. Continued delinquency beyond 90 days will lead to termination from the practice and any past due balance will be sent to collections.

In the event that my insurance company deems a service to be non-covered, as the patient, I understand that I am personally responsible for the full payment.

Court Related Services

All court related preparation, travel, testimony, and waiting time will be billed directly to me at a rate of $400 per hour for Physician, $300 per hour for Nurse Practitioners, and $200 per hour for Therapists, plus any travel expenses.

Termination of Treatment

I have the right to terminate my care at any time. I also understand that my provider may also terminate my care at any time. If care is terminated by the provider, emergency services and prescription refills will continue to be available for 30 days so as the patient may find another care provider and lapse in treatment may be prevented. Common reasons for termination of care by Gardenia Cove include:

1. Two consecutive no-shows or late cancellations or three no-shows or late cancellations within 12 months.
2. Failure to follow the mutually agreed upon treatment plan.
3. Threatening or verbally abusing any staff member or other patient.
4. Any illegal activity. This includes, but is not limited to, diverting controlled substance prescribed to you.
5. Violating confidentiality standards.

I understand that if I am transferred out of the practice, I will receive a letter by mail explaining termination of the provider-patient relationship. I will be given a list of other mental health providers in the area and will have the right to coordinate the transfer of care with Gardenia Cove and receive medication refills for one month after receiving notice of

termination. It is my responsibility to make sure Gardenia Cove has a current address on file in order to contact me.

Consent for Treatment

Gardenia Cove Mental Health, P.C. is a privately owned and operated psychiatric practice that is fully independent in providing clinical services. Our professional records are separately maintained and no one else can have access to them without your specific, written permission. We are fully responsible for the services we provide. This is a voluntary practice and patients are never obligated to receive services from our providers.

The undersigned patient of responsible party (parent, legal guardian, or conservator) authorizes and consents to services by the providers at Gardenia Cove Mental Health, P.C. These services may include assessments and evaluations, psychotherapy, medication management, the ordering of laboratory tests and diagnostic procedures, and other appropriate alternative therapies.

The undersigned person understands that he/she has the right to:

1. Be informed of and participate in the selection of treatment modalities.
2. Receive a copy of this consent.
3. Withdraw this consent at any time.

By signing, I acknowledge that I have read, understand, and agree with all policies and procedures above. I understand that if I do not understand or have questions about these policies, I may discuss them with my provider.

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Telehealth Policies and Procedures

Telehealth, for the purposes of this practice, is Video-Based Online Mental Health (VBOMH) services. VBOMH delivers mental health services when a provider and patient are not in the same physical location using interactive HIPPA and HITECH compliant audio and visual electronic systems. These services may also include electronic prescribing, appointment scheduling, and distribution of patient education materials.

Gardenia Cove Mental Health, P.C. strives to provide safe and quality care to our patients. For this reason we have taken the following steps to assure the care patients receive via electronic video and audio systems is safe and effective.

- Doxy.me and Zoom, the platforms Gardenia Cove uses to deliver Video-Based Online Mental Health (VBOMH), are HIPPA & HITECH compliant.
- All providers have and will remain in compliance with all applicable laws, rules, regulations, and state board requirements pertaining to the delivery of Telehealth.
- All providers will provide Telehealth services in a private secure environment with adequate lighting and reasonably soundproof for patient privacy.
- All providers will ensure that all documents containing protected health information or personal heath information, including prescriptions, are transmitted securely in accordance with all privacy rules including HIPPA.
- Gardenia Cove Mental Health, P.C. has proper protocols in place and have trained staff on protocols and procedures related to technical or other or other types of failure that may disrupt service delivery.
- The staff of Gardenia Cove Mental Health, P.C. are appropriately trained and will comply with proper claims submission procedures including the use of proper code modifiers for Telehealth.
- All providers have proper insurance coverage for Telehealth services.

Technical Difficulties/Urgent Situations

If you experience technical difficulties during a Telehealth session call the office to address the issue and reschedule if necessary. The office can be reached Monday-Thursday from 8:00am-12:00pm and 1:00pm-4:30pm and Fridays from 8:00am-12:00pm. For any urgent matters after hours or on the weekend, please call our office number and you will be connected with an answering service. If after hour calls are greater than 10 minutes or if continuous non-urgent calls are made after hours, a fee may be applied to patient account. This fee is not covered by insurance. Always call 911 or go to the nearest emergency room in the event of an emergency.

While Telehealth is a fantastic service that can make healthcare more accessible and convenient, it is not the same as a face-to-face visit and may not be for everyone. By consenting to treatment through Telehealth sessions you accept the limitations of this method of service.

I as the patient agree to the patient responsibilities listed below. Patient Responsibilities:

- I will be in the state of Alabama at the time services are rendered.
- I will not record any Telehealth sessions.
- I will inform my provider if any other person can hear or see any part of our session before the session begins.
- I understand that an internet connection and compatible device is required for Telehealth sessions. It is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. My provider is not responsible for providing internet connection or equipment, nor are they responsible should the session be interrupted by technical difficulties out of their control.
- I understand that courses of controlled substances cannot be started at Telehealth sessions.
- I am financially responsible for services rendered. If my insurance company does not cover Telehealth treatment, I may be charged the full visit fee for my appointment.
- No Show/Late Cancellation fees still apply for Telehealth visits.
- If I choose to pay for services out of pocket and not run visit fees through my insurance provider I recognize that any amount paid will not go towards meeting my

deductible.

By signing I, the patient, am consenting to receive Telehealth treatment and agree to follow these policies and procedures.

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I hereby authorize Gardenia Cove Mental Health to charge the credit or debit card on file in my patient account for all fees owed on my account related to professional services.

Fees will only be charged for:

Fee	Cost
Any Balance Deemed Patient Responsibility by Insurance Including Copays and Deductible Amounts Due	Variable
No Show and Late Cancelation	$100
Form Completion and Letter Preparation	$25/Form or Letter
Returned Check/Insufficient Funds	$35

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Group Therapy Consent Form

Welcome to your group experience!

Group counseling can be a powerful and valuable venue for healing and growth. It is the desire of your group facilitator that you reap all the benefits group has to offer. To help this occur, groups are structured to include the following elements:

-A safe environment in which you are able to feel respected and valued
-An understanding of group goals
-Investment by both your facilitator and members to produce a consistent group experience

A SAFE ENVIRONMENT

A safe environment is created and maintained by both the facilitator and its members. Primary ingredients are mutual respect and a chance to create trust. Another primary ingredient for a safe environment has to do with confidentiality. Your group facilitator is bound by law to maintain confidentiality, as group members are bound by honor to keep what is said n the group in the group. We realize the you may want to share what you are learning about yourself in group with a significant other. This is fine as long as you remember not to talk about how events unfold in group or in any other way compromise the confidentiality of other group members.

The facilitator of your group will ask you to sign a release form so that they can talk with your individual therapist. This is a safeguard for you which allows consultation between your group leader and your individual therapist should the need arise. This also provides you with extra support should a difficult issue come up in group that may need more individual attention.

LIMITS OF CONFIDENTIALITY

-If you are a threat to yourself or others (showing suicidal or homicidal intent), your facilitator may need to report your statements and/or behaviors to family, your therapist, or other appropriate mental health or law enforcement professionals in order to keep you and other safe.

-There are a broad range of events that are reportable under child protection statutes. Physical or sexual abuse of a child will be reported to Child Protective Services. When the victim of child abuse is over the age of 18, reporting is not

mandatory unless there are minors still living with the abuser, who may be in danger. Elder abuse is also required to be reported to the appropriate authorities.

-If a court of law orders a subpoena of case records or testimony, your facilitator will first assert “privilege” (which is your right to deny the release of your records, although this is not available in all states for group discussions). Your facilitator will release records if a court denies the assertion of privilege and orders the release of records. Records may also be released with your written permission. Records will include only your personal progress in group-not information about other group members.

-The facilitator may consult with other professionals regarding group interactions. This allows a freedom to gain other perspectives and ideas concerning how best to help you reach your goals in group. No identifying information is shared in such consultations unless a release has been obtained from you as a group member.

I understand that if my insurance company requests records they must be released or the claim will be denied. I further understand that if records are court ordered (not subpoenaed) for custody/divorce/legal issues that this office/clinician may be required to release them.

OTHER SAFETY FACTORS

-Members of a group may not use drugs or alcohol before or during group.
-Members of a group should not engage in discussion of group issues outside of group.
-Members of group should remember that keeping confidentiality allows for an environment where trust can be built and all members may benefit from the group experience.
-Your group facilitator will monitor discussions and maintain a respectful environment to keep safety and trust a priority.

ATTENDANCE

Your presence in group is highly important. A group dynamic is formed that helps create an environment for growth and change. If you are absent from the group, this dynamic suffers and affects the experience of all members of the group. Therefore, your facilitator would ask that you make this commitment a top priority for the duration of the group.

I understand that regular attendance will produce the maximum benefits but that I am free to discontinue treatment at any time unless ordered by the court. If I decide to do so I will notify the therapist at least two weeks in advance so that effective planning for continued care could be implemented. I understand that if I am not compliant with treatment recommendations I could be terminated from care. I understand that If I am not able to attend a group session/participate according to the program's expectations, it is important to reschedule at least 24 hours in advanced. If you are unable to attend any scheduled group session it is your responsibility to call to inform

the office that you will not be able to keep your scheduled appointment. We request that you call at least 24 hours prior to your appointment day and time. Any appointments you fail to call to cancel and you fail to keep will incur a full session fee- this fee is not charged to your insurance (if any), it is your responsibility for any session fees that may result in the failure to notify of an absence within established time period. Same day cancellations may also incur a full session fee that is your sole responsibility. I understand that more than two (2) consecutive no-shows (cancellations without a call in advance) and/or non-compliance with counseling services, could result in referral and/or termination of services (if applicable).

Because it usually take several sessions for clients to “settle in” and receive the full benefits a therapy group provides, we ask incoming members to make a 12 week commitment when they join a group. We also ask members to give a 3 week notice when they decide to leave a group. We ask this because each member of a group is important-your presence and your absence impacts members and facilitators- and we want to allow time for members to process when members choose to leave.

WHAT TO EXPECT

Group time consists of both teaching and processing time. Processing may revolve around an issue one member of the group is working on with time for structured feedback and reactions by other members of the group. Also, at times, the group my focus on a topic with all members verbally participating. In either case, the group dynamic offers a place where you can experience support, give support, understand more clearly how you relate to others, and examine your own beliefs about yourself and the world around. These dynamics provide a very powerful environment for change.

Remember, the more you give of yourself during these sessions, the more you will receive. The more honest and open you are, the more you allow for insight and growth.

VOLUNTARY PARTICIPATION IN TREATMENT

I know of no reasons I/he/she/we should not undertake this therapy and I/he/she/we agree to participate fully and voluntarily. I understand that participation/involvement in therapy is expected; I will work on the goals identified through each group session or participate as expected and/or discussed with me (or in the case that this is being signed for a minor child/impaired adult, will assist my son/daughter/ward/etc. in working on the goals identified or encourage participation in the group therapy sessions.) I also understand that a satisfactory outcome of therapy can not be guaranteed and agree to hold harmless the clinician for any and all outcomes of therapy.

REFERRAL FOR ADJUNCTIVE TREATMENT

Follow through is expected when referrals are made for any adjunctive treatment that may be deemed important to supplement the current level of service provisions. If I (or son/daughter/ward/etc.) refuse to follow the recommendations of my (or son/daughter/ward/etc.) treating professional, I acknowledge that my (or son/daughter/ward/etc.) involvement with the clinician, could be placed at risk and may result in a termination of services.

FEES

The discounted out of pocket fee for this group is $30 per 60 minute session. You must sign a consent form for your individual therapist in order to participate in this group. You are responsible to pay for each session except in the case of a true emergency.

My signature is to indicate that I have read and understand each of the above consents and that I give my knowing and consent for the items above.

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable
federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization:
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object:

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact your doctor if you have any other questions about privacy practices.

Gardenia Cove
MENTAL HEALTH, P.C.

With my signature below I acknowledge that I have read and agree to this document.

_____

Print Patient Name

_____

Patient Signature

_____

Date of Signature