**INFORMED CONSENT**

Thank you for choosing New Transitions Counseling. Today’s appointment with Russ Exlos-Raber MA, LPCC will take approximately 45 – 50 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Russ holds dual Bachelor degrees from Otterbein University and dual Master’s degrees in education and counseling from Bowling Green State University. He is licensed by the State of Ohio both as a Licensed Professional Clinical Counselor and a Licensed Professional Educator. Russ has over 25 years of experience working with children, adolescents, and teens in a variety of capacities. His internship and counseling experiences range from adults and families to children, as well as chemical dependency issues. Areas of particular expertise include teen anger/adjustment issues, anxiety and adjustment disorders, play/child therapy, and sexuality/orientation/transgender issues. Russ practices standard cognitive-behavior therapy and solution focused therapy for most conditions; although other treatment approaches (such as sand tray/play/reality therapy) are used depending on the person or condition. Treatment practices, philosophy and plan imitations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: shared with our a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical or sexual abuse; then, by Ohio State Law, I am obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs me that you are in danger of harming yourself or others, information necessary for case supervision or consultation and e) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary and I am unable to return your call within 15 minutes, the client or guardian understands that they are to contact their localemergency room in the community (911) for those services. Russ Exlos-Raber MA, LPCC, will follow those emergency services with standard counseling and support to the client or the client's family. The American Correctional Association ethics policy prohibits therapists from accepting invitations on social media. New Transitions Counseling therapists can actively look up your online social media accounts if the need would be there.

**Signature(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_**

**FINANCIAL/INSURANCE ISSUES:**

As a courtesy, we will bill your insurance company, HMO, responsible party or third-party payer for you if you wish. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $150.00 we will need to ask that you pay for services when rendered. I understand if I have an unpaid balance to New Transitions Counseling and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney’s fees if so incurred during collection efforts.

In order New Transitions Counseling or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that New Transitions Counseling and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

Our hourly fees are $100.00 per every 50-minute clinical hour. Our diagnostic assessment is $120.00. We also charge for other professional services based on your needs. These services will be billed in 15 increments based on the $100.00 hourly rate. These include telephone calls, phone calls to educational settings, letter writing to authorized contacts and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time even if we are called to testify for another party. Because of the extra time involved, we will charge $150.00 per hour for preparation and attendance at any legal proceeding. This payment is required in advance of the hearing based on an approximated time of need. (Example 3 hours would equal $450.00 in advance.) Any time not spent will be reimbursed back to the paying client.

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed a $75.00 no show/no cancel fee. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. You may have a copy of this form if requested.

**Signature(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_**

**COORDINATION OF TREATMENT:** It is important that all health care providers work together. Many insurance companies require this cooperation for continuity of care and payment reimbursement. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. If you prefer to decline consent no information will be shared.

\_\_\_\_**You may inform my physician(s) \_\_\_\_I decline to inform my physician**

**PHYSICIAN NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CLINIC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_**

New[](http://en.wikipedia.org/wiki/Image%3ATe_cross.svg)ransitions Counseling L **NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:** I/We have read and received a copy of the Notice of Privacy Practices and Client Rights document.

**Signature(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

May we contact you at home (circle one) yes **no**? May we contact you at work **yes no?** May we contact you by cell phone yes **no?** Where may we contact you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_?

**CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:** I/We consent that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ may be treated as a client at New Transitions Counseling. At times, it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the timeliest treatment for you and your children. **It is mandatory for treatment of** **children that we have proof of custody even if shared parenting is ordered**. Failure to provide legal documents may result in the rescheduling of your appointment.

**Signature(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Consent to Treatment: Your signature below indicates that you have read all the information in our intake packet and agree to treatment by our agency and to abide by our policies during our professional relationship.

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Clinician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Registration Form
Patient Demographic Information**

|  |  |
| --- | --- |
| **Patient Name:** | **Social Security #:** |
| **Street Address:** | **Date of Birth:** |
| **City, State, Zip Code:** | **Home Phone:** |
| **Gender:** | **Work Phone:** |
| **Email Address:** | **Mobile Phone:** |
| **Primary Physician:** | **Psychiatrist (if any):** |
| **Emergency Contact Person:** | **Emergency Contact Phone:** |
| **How did you hear about us?** | **Marital Status:** |

**Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as patient)**

|  |  |
| --- | --- |
| **Responsible Party:** | **Home Phone:** |
| **Street Address:**  | **Work Phone:** |
| **City, State, Zip Code:** | **Mobile Phone:** |
| **Relationship to Patient:** | **Responsible Party SSN:** |

Insurance Information

|  |  |
| --- | --- |
| **Primary Insurance:** | **Policy Holder Name:** |
| **Company Address:** | **Policy Holder Date of Birth:** |
| **City, State, Zip Code:** | **Identification Number:** |
| **Company Phone:** | **Policy/Group Number:** |
| **Employer:** | **Policy Holder SSN:** |
| **Secondary Insurance:** | **Policy Holder Name:** |
| **Company Address:**  | **Policy Holder Date of Birth:** |
| **City, State, Zip Code:**  | **Identification Number:** |
| **Company Phone:** | **Policy/Group Number:** |
| **Employer:**  | **Policy Holder SSN:** |

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Questionnaire**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Age:** \_\_\_\_\_\_\_\_\_\_\_

**Medication Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current medications:**
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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**Physician diagnosed medical problems:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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**Why are you seeking counseling?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Does your \_\_\_\_\_Father \_\_\_\_\_Mother \_\_\_\_\_Brother(s) \_\_\_\_\_Sister(s) have a history of alcohol or drug abuse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, do you understand the need to stop use of all tobacco products immediately? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you use alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, would you describe your use as -- Minimal \_\_\_\_\_\_\_\_\_ Moderate \_\_\_\_\_\_\_\_\_\_\_\_\_ Heavy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Are you using any form of illegal drugs? YES \_\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_
* Have you been convicted of any type of drug or alcohol related crime within the past 10 years?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, what was the charge and punishment (sentence) passed down?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Do you understand that providing non-functional or unreachable phone numbers &/or addresses will in all likelihood result in treatment discontinuation at this facility?
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Home # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Is it your statement that you have answered all questions and inquiries in a truthful and honorable manner? YES \_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Signature** **Date**

No Show, Late Cancellation and Co-payment Policy

1. I understand that I will be charged a LATE CANCELLATION fee of $75 if I fail to give at least 24 hour notice prior to cancelling my appointment.

2. I understand that I will be charged a NO-SHOW fee of $75 if I fail to show for my appointment.

3. I understand that these charges are an out of pocket expense and that my insurance carrier will not cover these charges.

4. I understand that the therapy session will last 60 minutes. I understand that if I am late to the appointment, I will still have to end the session at the allotted time. By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this therapist.

5. I understand if my balance is $150 or more, my therapist has the option to discontinue services until my is under the allowable amount of $150.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Responsible Party

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**CLIENT RIGHTS**

**Right to request how we contact you**

It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way.

**Right to release your medical records**

You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization

**Right to inspect and copy your medical and billing records.**

You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

**Right to add information or amend your medical records**.

If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

**Right to an accounting of disclosures.**

You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

**Right to request restrictions on uses and disclosures of your health information.**

You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

**Right to complain.**

If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services 233 N. Michigan Ave Suite 240 Chicago Ill 60601 PH 312-886-2359. An individual will not be retaliated against for filing such a complaint.

**Right to receive changes in policy.**

You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager Kim Boyer.

**HIPAA NOTICE OF PRIVACY PRACTICES**

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

**Effective date: April 14, 2003**

New Transitions Counseling has been and will always be totally committed to maintaining client’s confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

**Uses and disclosures of your health information for the purposes of providing services.** Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

**TREATMENT** We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. This could include consultants and potential referral sources.

**PAYMENT** Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

**HEALTHCARE OPERATIONS** We may need to use information about you to review our treatment procedures and business activity. Information maybe used for certification, compliance and licensing activities.

**Other uses or disclosures of your information which does not require your consent** There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Ohio State Law, we are obligated to report this to the Department of Children and Family Services; if you provide information that informs us that you are in danger of harming yourself or others; information to remind you of /or to reschedule appointments or treatment alternatives and finally information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.