Associates in Psychotherapy

Thank you for calling Associates in Psychotherapy, LLC for an appointment. Please read and complete the information in this envelope and bring it with you, along with your insurance card, to your first appointment. If you have questions about anything, our office staff or your therapist will help you find the answers and explain our procedures. Please arrive 10 minutes early the first time to provide our office staff with your insurance information.

A parent must sign all forms for children 18 and younger. If the child is 14 or older, they must sign also. A parent **must** attend the initial counseling session if the child is under 18.

We are looking forward to meeting with you.

4700 Dresser Drive, Suite 100, Janesville, WI 53546 608-752-7255

636 Park Avenue, Beloit, WI 53511 608-365-4313

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ASSOCIATES IN PSYCHOTHERAPY, LLC

4700 Dresser Drive, Ste. 100, Janesville, WI 53546 • 608-752-7255 • Fax 608-752-6942
www.AssociatesInPsychotherapy.com

ADULT INTAKE/EVALUATION

Date_____ Therapist_____ Referred by_____

Client's Name_____ Date of Birth_____
Maiden Name_____ Level of Education_____
Age_____ Sex_____ Race_____ Cell Phone Number_____
Address_____ Home Phone Number_____
_____
What number can we leave a message on? Cell_____ Home_____ Work_____
Work Status/Occupation_____ Place of Employment_____
( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated ( ) Significant Other

If married:

Spouse's Name_____ Spouse's Date of Birth_____
Age_____ Sex_____ Race_____ Level of Education_____
Work Status/Occupation_____ Place of Employment_____
Date of Marriage_____How Long?_____ Employed Above for How Long? _____

Previous Marriage(s)

Ex-spouse's Name_____ Date of Marriage_____ How long?_____
Ex-spouse's Name_____ Date of Marriage_____ How long?_____

Children/Step-Children (First and Last Name)

Name_____ Age_____ School/Occupation_____
Name_____ Age_____ School/Occupation_____
Name_____ Age_____ School/Occupation_____
Name_____ Age_____ School/Occupation_____
Name_____ Age_____ School/Occupation_____

FAMILY OF ORIGIN

Family Member	Name	Age	Education	Occupation	Marital Status	If Deceased Date	Cause of Death
Mother							
Father							
Step-Mother							
Step-Father							

Brothers/Sisters

Name	Age	Education	Occupation	Marital Status	If Deceased Date	Cause of Death

Where were you born and raised?_____
Are your parents divorced? ( ) Yes ( ) No If yes, how old were you?_____

FAMILY MEDICAL HISTORY

Please check all areas which apply to your family's medical history and indicate the relationship of that person who it pertains to.

MEDICAL PROBLEMS	FAMILY MEMBER	MEDICAL PROBLEMS	FAMILY MEMBER
( ) Alcoholism		( ) Hepatitis	
( ) Aneurysm		( ) High Blood Pressure	
( ) Anxiety		( ) Hypoglycemia	
( ) Attention Deficit Disorder		( ) Hysterectomy	
( ) Attention Deficit /Hyperactivity		( ) Kidney Disease	
( ) Autism Syndrome		( ) Lung Problems	
( ) Back Problems		( ) Menopause	
( ) Bipolar Disorder		( ) Miscarriage	
( ) Blindness		( ) Obesity	
( ) Cancer		Obsessive	
( ) Colitis		( ) Compulsive Disorder	
( ) Crohn's Disease		( ) P.M.S.	
( ) Deafness		( ) Panic Attacks	
( ) Depression		Posttraumatic Stress	
( ) Diabetes		( ) Disorder	
( ) Drug Abuse		( ) Schizophrenia	
( ) Ear Infections		( ) Seizures	
( ) Eating Disorders		( ) Sinus Infections	
( ) Emphysema		( ) Sleep Disorders	
( ) Head Injury		( ) Stroke	
( ) Headaches/Migraines		( ) Thyroid Problems	
( ) Heart Disease		( ) Tourette Syndrome	
( ) Heart Pain (Angina)		( ) Tuberculosis	
( ) Heart Attack		( ) Ulcers	
( ) Other		( ) Other	

Past Psychiatric/Psychotherapy Treatment:

Have you been in therapy before? ( ) Yes ( ) No Reason for previous treatment:_____

Where?_____ When?_____ Therapist (if known):_____

Medications taken:_____

Response to treatment:_____

Any hospitalizations for psychiatric purposes?_____ If so, where?_____

What family members have been treated for psychiatric purposes?_____

History of suicide in your family?_____ If so, who?_____

MEDICAL INFORMATION and HISTORY

Doctor(s)_____ Clinic_____ Last Physical_____

Doctor(s)_____ Clinic_____ Last Physical_____

Doctor(s)_____ Clinic_____ Last Physical_____

Illnesses

_____

_____

Surgeries

_____

_____

Medication Allergies

_____

Medications

_____

_____

_____

_____

Current Living Situation

Alone _____ With Spouse_____ Significant Other_____ With Friend_____ With Relatives_____ With Parents_____

Quality of Family Relationship Good_____ Fair_____ Poor_____

Have you service in the military? Yes_____ No_____ Which branch?_____

Has a close friend or member of your family died in the past two years?

Yes_____ No_____ If yes, who?_____

Other significant losses during the past two years?

Marriage_____ Relationship_____ Pet_____ Job_____ Home_____ Other_____

Is your work satisfying? Yes_____ No_____ If not, explain why:_____

Major Source of Annual Income

Job_____ Spouse_____ Parents_____ Children_____ Relatives_____ Social Security_____ Pension/Savings_____

Disability_____ Does Not Apply_____ Other_____

Organizations, Hobbies, Skills, Interests:

_____

_____

_____

Current use of alcohol

None____ Occasional____ Daily____ Heavy____ Binge drinking____ Marked by occasional attempts at abstinence_____

Current use of drugs

None_____ Occasional_____ Regular_____ Heavy_____ Illegal_____ Prescription_____

Have you or anyone else ever had concerns about your alcohol, medication or drug use?

Yes_____ No_____ If yes, please explain_____

Have you ever been treated for alcohol or other drug abuse?

Yes_____ No_____ If so, when?_____

Have you or anyone else ever had concerns about your weight and eating habits?

Yes_____ No_____ If yes, please explain_____

Current Cigarette Smoking

Never_____ Quit_____ >1 pack per day_____ 1 pack per day_____ < 1 pack per day_____

While you were growing up, did you have any problems with:

Bedwetting_____ Fears_____ Friends_____ Learning to talk_____ Learning to walk_____ Nail biting_____ School_____

Nightmares, recurrent dreams_____ Unusual illnesses_____ Toilet training_____ Sleep disturbance_____ None_____

Other_____

Have you ever been sexually abused? Yes_____ No_____ If yes, please explain_____

Have you ever been physically abused? Yes_____ No_____ If yes, please explain_____

Have you ever been emotionally abused? Yes_____ No_____ If yes, please explain_____

Sexual Preference Heterosexual_____ Bisexual_____ Homosexual_____ Unknown_____

Current Legal Problems

Child Custody_____ Divorce_____ Criminal Charges_____ None_____ Parole/Probation_____ Civil Suit_____

History of Legal Problems

Arrest_____ Driver's License Revoked_____ Juvenile Record_____ Prison Record_____ Other:_____ None_____

History of Violent Acts

Assault_____ Child Abuse_____ Spouse Abuse_____ Suicide Attempt_____ Murder_____ None_____

Current Violent Thoughts

Injury to Others_____ Self-injury_____ Other:_____ None_____

What are the problems and symptoms for which you are seeking help?

_____ Marriage/Relationship
_____ Divorce
_____ Parent/Child
_____ Family
_____ Friends
_____ Work
_____ Depression
_____ Grieving
_____ Anxiety and Worry
_____ Panic Attacks
_____ Social Anxiety
_____ Social Isolation
_____ Someone Wants Me to Get Help
Who? _____

_____ Self-Esteem
_____ Mood Swings
_____ Manic Episodes
_____ Obsessive/Compulsive
_____ Physical Health
_____ Anger
_____ Sleep
_____ Eating
_____ Impulsive Behaviors
_____ Self-Harm Behaviors
_____ Suicidal Thoughts
_____ Homicidal Thoughts

_____ Disturbing Thoughts
_____ Alcohol Use
_____ Drug Use
_____ Abuse/Trauma Recovery
_____ Sexual Functioning
_____ Sexual Orientation
_____ Learning
_____ Memory
_____ Attention/Concentration
_____ Autism
_____ Criminal Charges
_____ Other: _____

When did these problems begin? _____

Do these problems affect your:

( ) Health ( ) Personal Relationships ( ) Work Performance ( ) No Significant Effect

Your Strengths:

_____ Assertiveness
_____ Self-Esteem
_____ Support Network
_____ Intelligence
_____ Problem-Solving Skills
_____ Self-Care
_____ Functioning at Home, Work, School

_____ Empathy
_____ Stress Management
_____ Spirituality
_____ Insight
_____ Judgment
_____ Boundaries
_____ Motivation

_____ Mood Regulation
_____ Behavior
_____ Self-Comforting
_____ Attention and Concentration
_____ Interests, Hobbies and Organizations

What are the major stressors in your life at this time? _____

_____

_____

On a scale of 1 to 10, my current functioning is at _____

What impact are your problems having on your daily functioning? _____

_____

_____

What is going well in your life? _____

_____

_____

What strategies or coping skills have you used in the past? _____

_____

_____

My goals for therapy are? _____

_____

_____

How will you know when things are getting better? _____

_____

_____

Signature: _____ Date: _____

Reviewed by: _____ Date: _____
Therapist

Associates in Psychotherapy

INFORMED CONSENT FORM

Client: _____

I have been provided information regarding psychotherapy treatment and understand I have the right to additional information concerning the following:

a. the benefits of proposed treatment;
b. the way the treatment is to be administered;
c. alternative treatment modes;
d. the probable consequences of not receiving proper treatment;
e. the time period for which the Informed Consent is effective;
f. the right to withdraw the Informed Consent at any time in writing.
g. I understand that if I receive medications from this clinic, I have the right to know the reasons for the prescription of that medication as well as its potential side effects. I also understand that is my responsibility to ask questions if I do not understand the directions, purpose or side effects of that medication, and to report problems to my physician at this clinic.
h. Before the clinic involuntarily discharges a consumer because of the consumer's inability to pay for services or for behavior that is reasonably a result of mental health symptoms, the clinic notifies the consumer in writing of the reasons for the discharge, the effective date of the discharge, sources for further treatment, and of the consumer's right to have the discharge reviewed, prior to the effective date of the discharge, by the Behavioral Health Certification Section, Division of Quality Assurance, whose address is P.O. Box 2969, Madison, WI 53701-2969, fax (608) 261-0655. In general we do not involuntarily discharge clients for the above reasons. See Consumers Rights and Grievance Procedures section.

In addition, I have been informed orally of and been given access to a written copy of the Client's Treatment Rights and Grievance Procedure.

Can we leave a message on your home answering machine and/or cell phone?

Yes _____ No _____

_____ _____
Signature of Client Date

_____ _____
Person Authorized by Client Relationship to Client

_____
Witness

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ASSOCIATES IN PSYCHOTHERAPY, LLC
Business Policy & Patient Agreement

Main Office
4700 Dresser Drive, Suite 100
Janesville, WI 53546
608-752-7255

Beloit Branch
636 Park Street
Beloit, WI 53511
608-365-4313

Welcome to Associates in Psychotherapy, LLC. We have designed this packet to help you understand our policies and procedures along with your rights as our client. We ask that you read this informational packet. Your signature is needed at the end of this packet to indicate your understanding and willingness to participate and abide by these policies. We want you to know that we are dedicated to giving you quality care. Please feel free to ask questions.

OFFICE HOURS: Because of the diversity of our clinical staff, our hours range from 8:00 a.m. to 7:00 p.m. Monday through Friday. The office staff is available from 8:30 a.m. to 5:00 p.m. Monday through Thursday and 8:30 a.m. to 4:00 p.m. on Friday with the exception of holidays. You may leave a message with our answering service after normal business hours. They know how to contact your therapist.

FEE INFORMATION:

Nurse Practitioner	*Licensed Psychologists*	*Therapists*
Psychiatric Evaluation - $260	Initial Assessment - $210	Initial Assessment - $190
Medication Evaluation - $120	Therapy Sessions - $150/$225	Therapy Sessions - $130/$195
	Family Therapy - $160	Family Therapy - $140

FEES NOT REIMBURSED BY INSURANCE COMPANIES

Late Cancellation/Now Show Fees:	Nurse Practitioner	$ 50.00
	Psychologist	$ 70.00
	Therapist	$ 60.00
Record Requests:		
Administrative Costs		$ 26.00
Copying Fee per Page		$ 0.45
Actual Cost of Postage		
Consultation or Other Services:		
Per hour		$190.00
Court Preparation and/or Testimony:		
Per hour		$190.00

24-HOUR CANCELLATION POLICY: When it is necessary to cancel an appointment, you are expected to do so 24-hours in advance, even if it means leaving a message with our answering service. As a courtesy, Associates In Psychotherapy, LLC, attempts to make reminder calls regarding current appointments, however, there are times when this may not occur. Ultimately it is the client's responsibility to keep their appointments.

Note that TWO No-Shows and/or Late Cancellations in a one-year period may be cause for termination of treatment at Associates in Psychotherapy.

I HAVE READ AND I UNDERSTAND THE ABOVE NONREFUNDABLE FEES AND CANCELLATION POLICY:

_____ (Initial)

NOTE TO PARENT(S) OF MINOR CHILDREN: It is the clinic's policy to accept parent's signature on these forms as an agreement to be responsible for payment of minor children's services with this clinic. In separated or divorced families, the person who initiates services with us is held financially responsible. We do not bill another person or an estranged spouse unless that individual informs us in writing of his or her willingness to pay for services rendered. Should another party be willing to assume financial responsibility for our services, they may sign the Business Policy & Patient Agreement form.

Parent(s) must attend the initial session with the child. Children are not to be left in the waiting room unsupervised. If only temporary guardianship has been issued, the minor's biological parent must sign all the admitting paperwork and releases. No minor with a guardian will be treated until guardianship has been verified.

PRESCRIPTION REQUESTS: Follow instructions from prescriber.

INSURANCE AND BILLING INFORMATION: While our services may be covered by private insurance, the ultimate responsibility for payment of your account is yours.
Not all insurance policies are the same, therefore, it is advisable that you contact your insurance carrier to determine your individual benefit package.

PATIENTS COVERED BY INSURANCE: Please pay your deductible or co-payment at the time of service.

PATIENTS NOT COVERED BY INSURANCE: Payment is to be made at the time of service.

I have read the above and I hereby agree to be directly responsible to Associates in Psychotherapy, LLC, for charges incurred and I acknowledge that I fully understand the above and will comply with these guidelines. Furthermore, I agree that I have received a copy of this packet to take home with me.

_____ _____

Patient or Responsible Party Date

Associates in Psychotherapy

SIGNATURE ON FILE

- I authorize the use of this form on all my insurance submissions.
- I authorize release of information to all my insurance companies.
- I understand that I am responsible for my bill.
- I authorize my doctor/therapist to act as my agent in helping me obtain payment from my insurance companies.
- I assign insurance benefits and authorize my insurance company to make payments directly to my doctor/therapist.

_____ _____

Signature Date

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Associates in Psychotherapy

RECEIPT OF NOTICE OF PRIVACY PRACTICES
Federal Regulations

Patient Name: _____

Date of Intake: _____

My signature on this form acknowledges that I have received a copy of Associates in Psychotherapy's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Associates in Psychotherapy and of my rights with respect to my health information.

I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

_____ _____
Patient's Signature Date

_____ _____
Signature of Patient's Representative Date
(If patient is unable to sign.)

TO BE COMPLETED BY ADMITTING CLINICIAN IF FORM IS NOT SIGNED

1. Was the patient provided with a copy of the Notice of Privacy Practices?

   ☐ Yes ☐ No

2. Briefly describe the efforts made to obtain the patient's acknowledgement of receipt of the Notice and explain why the patient was unable or unwilling to sign this form: _____

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CLIENT RIGHTS and the GRIEVANCE PROCEDURE for COMMUNITY SERVICES

for Clients Receiving Services in Wisconsin for
Mental Illness, Alcohol or Other Drug Abuse

CLIENT RIGHTS

When you receive any type of service for mental illness, alcoholism, drug abuse, or a developmental disability, you have the following rights under Wisconsin Statute sec. 51.61(1) and HFS 94, Wisconsin Administrative Code:

PERSONAL RIGHTS

- You must be treated with dignity and respect, free from any verbal, physical, emotional, or sexual abuse.
- You have the right to have staff make fair and reasonable decisions about your treatment and care.
- You may not be treated unfairly because of your race, national origin, sex, age, religion, disability, or sexual orientation.
- You may not be filmed, taped, or photographed unless you agree to it.

TREATMENT AND RELATED RIGHTS

- You must be provided prompt and adequate treatment, rehabilitation, and educational services appropriate for you.
- You must be allowed to participate in the planning of your treatment and care.
- You must be informed of your treatment and care, including alternatives to and possible side effects of treatment, including medications.
- No treatment of medication may be given to you without your written informed consent, unless it is needed in an emergency to prevent serious physical harm to you or others, or a court orders it. (If you have a guardian, however, your guardian may consent to treatment and medications on your behalf).
- You may not be given unnecessary or excessive medication.
- You may not be subject to electroconvulsive therapy or any drastic treatment measures such as psychosurgery or experimental research without your written informed consent.
- You must be informed in writing of any costs of your care and treatment for which you or your relatives may have to pay.
- You must be treated in the least restrictive manner and setting necessary to achieve the purposes of admission to the program, within the limits of available funding.

RECORD PRIVACY AND ACCESS

Under Wisconsin Statute sec. 51.30 and HFS 92, Wisconsin Administrative Code:

- Your treatment information must be kept private (confidential), unless the law permits disclosure.
- Your records may not be released without your consent, unless the law specifically allows for it.
- You may ask to see your records. You must be shown any records about your physical health or medications. Staff may limit how much you may see of the rest of your treatment records while you are receiving services. You must be informed of the reasons for any such limits. You may challenge those reasons through the grievance process.
- After discharge, you may see your entire treatment records if you ask to do so.
- If you believe something in your records is wrong, you may challenge its accuracy. If staff will not change the part of your record you have challenged, you may file a grievance and/or put your own version in your record.
- A copy of sec. 51.30, Wis. Stats., and/or HFS 92, Wisconsin Administrative Code, is available upon request.

GRIEVANCE PROCEDURE AND RIGHT OF ACCESS TO COURTS

- Before treatment is begun, the services provider must inform you of your rights and how to use the grievance process. A copy of the Program's Grievance Procedure is available upon request.
- If you feel your rights have been violated, you may file a grievance.
- You may not be threatened or penalized in any way for presenting your concerns informally by talking with staff, or formally by filing a grievance.
- You may, instead of filing a grievance or at the end of the grievance process, or any time during it, choose to take the matter to court to sue for damages or other court relief, if you believe your rights have been violated.

GRIEVANCE RESOLUTION STAGES

Informal Grievance Process

- You are encouraged to talk with your therapist or the office staff about any concerns you have.
- If the matter is not resolved, you are encouraged to talk to the Clinical Director, Elizabeth C. Magnus, Ph.D.
- However, you do not have to do this before filing a formal grievance with your service provider.

Grievance Investigation-Formal Inquiry

- If you want to file a grievance, you should do so within 45 days of the time you become aware of the problem. The program manager for good cause may grant an extension beyond the 45-day limit.
- The program's Client Right Specialist (CRS) will investigate your grievance and attempt to resolve it.
- Unless the grievance is resolved informally, the CRS will write a report within 30 days from the date you filed the formal grievance. You will get a copy of the report.
- If you and the program manager agree with the CRS's report and recommendations, the recommendations shall be put into effect within an agreed upon time frame.
- You may file as many grievances as you want. However, the CRS will usually only work on one at a time. The CRS may ask you to rank them in order of importance.

Program Manager's Decision

- If the grievance is not resolved by the CRS's report, the program manager or designee shall prepare a written decision within 10 days of receipt of the CRS's report. You will be given a copy of the decision.

County Level Review

- If you are receiving services from a county agency, or a private agency and a county agency is paying for your services, you may appeal the program manager's decision to the County Agency Director. You must make this appeal within 14 days of the day you receive the program manager's decision. You may ask the program manager to forward your grievance or you may send it yourself.
- The County Agency Director must issue his or her written decision within 30 days after you request this appeal.

State Grievance Examiner

- If your grievance went through the county level of review and you are dissatisfied with the decision, you may appeal it to the State Grievance Examiner.
- If you are paying for your services from a private agency, you may appeal the program manager's decision directly to the State Grievance Examiner.
- You must appeal to the State Grievance Examiner within 14 days of receiving the decision from the previous appeal level. You may ask the program manager to forward your grievance to the State Grievance Examiner or you may send it yourself. The address is: State Grievance Examiner, DSL, P.O. Box 7851, Madison, WI 53707-7581.

Final State Review

- Any party has 14 days of receipt of the written decision of the State Grievance Examiner to request a final state review by the Administrator of the Division of Supportive Living or designee. Send your request to the DSL Administrator, P.O. Box 7851, Madison, WI 53707-7851.

You may talk with staff or contact your Client Rights Specialist, whose name is shown below, if you would like to file a grievance or learn more about the grievance procedure used by the program from which you are receiving services.

Your Client Right Specialist for Formal Grievances is:

Jennifer Campbell, Psy.D.
c/o Associates in Psychotherapy, LLC
4700 Dresser Drive, Ste. 100
Janesville, WI 53546

Ask Debbie Kravick, Office Manager, for the grievance forms.

NOTE: There are additional rights within sec. 51.61(1) and HFS 94, Wisconsin Administrative Code. They are not mentioned here because they are more applicable to inpatient and residential treatment facilities. A copy of sec. 51.61 Wis. Stats. And/or HFS 94, Wisconsin Administrative Code is available upon request.

FEDERAL REGULATIONS

Privacy Practices

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996
HIPAA PRIVACY COMPLIANCE

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.

USE AND DISCLOSURE OF HEALTH INFORMATION

Provider (Associates in Psychotherapy) may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, for purposes of providing you treatment, obtaining payment for your care, and conducting heal care operations. Provider has established a policy to guard against unnecessary disclosure of your health information.

The following is a summary of the circumstances under which and purposes for which your health information may be used and disclosed:

To Provide Treatment. Provider may use your health information to provide care to you and disclose your health information to others who provide care to you. For example, physicians involved in your care will need information about your symptoms in order to prescribe appropriate medications. Provider also may disclose your health care information to individuals outside of Provider involved in your care, such as your Primary Care Physician or the on-call psychiatrist.

To Obtain Payment. Provider may include your health information in invoices to collect payment from third parties for the care you may receive from Provider. For example, Provider may be required by your health insurer to provide or obtain prior approval from your insurer and may need to explain to the insurer your need for health care and the services that will be provided to you.

To Conduct Health Care Operations. Provider may use and disclose health information for its own operations in order to facilitate the function of Provider and as necessary to provide quality care to all of Provider's patients. Health care operations include activities such as quality assessment and improvement activities include: protocol development, case management and care coordination; contacting health care providers and patients with information about treatment alternatives and other related functions that do not include treatment; professional review and performance evaluation; training programs including those in which students, trainees, or practitioners in health care learn under supervision; training of non-health care professionals; accreditation, certification, licensing, or credentialing activities; and review and auditing, including compliance reviews, medical reviews, legal services, and compliance programs.

For Appointment Reminders. Provider may use and disclose your health information to contact you as a reminder that you have an appointment for treatment or medical care with Provider.

When Legally Required. Provider will disclose your health information when it is required to do so by any Federal, State, or local law.

To Report Abuse, Neglect, or Domestic Violence. Provider is allowed to notify government authorities if Provider believes a patient is the victim of abuse, neglect, or domestic violence. Provider will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

To Conduct Health Oversight Activities. Provider may disclose your health information to a health oversight agency for activities including: audits, civil, administrative, or criminal investigations; inspections; licensure or disciplinary action. Provider, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of and is not directly related to you receipt of health care or public benefits.

In Connection with Judicial and Administrative Proceedings. As permitted or required by State law, Provider may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other protecting your health information.

For Law Enforcement Purposes. As permitted or required by State law, Provider may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

In the Event of a Serious Threat to Health or Safety. Provider may, consistent with applicable law and ethical standards of conduct, disclosure your health information if Provider, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, the Federal regulations authorize Provider to use or disclose your health information to facilitate specified government functions relating to the military and veterans, national security and intelligence activities, protective services for the President and others, medical suitability determinations and inmates and law enforcement custody.

For Worker's Compensation. Provider may release your health information for worker's compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other what is stated above, Associates in Psychotherapy will not disclose your health information other than with your written authorization. If you or your representative authorizes Provider to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that Provider maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on Provider's disclosure of your health information to someone who is involved in your care or the payment of your care. However, Provider is not required to agree to your request. If you wish to make a request for restrictions, please contact: Debbie Kravick, Office Manager, at 608-752-7255.

Right to Receive Confidential Communications. You have the right to request that Provider communicate with you in a certain way. For example, you may ask that Provider only conduct communications pertaining to your health information with you privately with no other family members present. If you wish to receive confidential communications, please contact: Debbie Kravick, Office Manager, at 608-752-7255. Provider will not request that you provide any reasons for your request and will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy your Health Information. You have the right to inspect and copy your health information, including billing records. A request to inspect and copy records containing your health information may be made to Debbie Kravick, Office Manager, at 608-752-7255. If you request a copy of your health information, Provider may charge a reasonable fee for copying and assembling costs associated with your request.

Right to Amend your Health Information. You or your representative have the right to request that Provider amend your records, if you believe your health information records are incorrect or incomplete. That request may be made as long as the information is maintained by Provider. A request for an amendment of records must be made in writing to Debbie Kravick, Office Manager, c/o Associates in Psychotherapy, 4700 Dresser Dr., Ste. 100, Janesville, WI 53546. Provider may deny the request if it is not in writing or does not include a reason for the amendment. The request also may be denied if your health information records were not created by Provider, if the records you are requesting are not part of Provider's records, if the health information you wish to amend is not part of the health information you or your representative are permitted to inspect and copy, of if, in the opinion of Provider, the records containing your health information are accurate and complete.

Right to an Accounting. You or your representative have the right to request an accounting of disclosures of your health information made by Provider for certain purposes, which may include disclosures authorized by law. The request for an accounting must be made in writing to Debbie Kravick, Office Manager, c/o Associates in Psychotherapy, 4700 Dresser Dr., Ste. 100, Janesville, WI 53546. The request should specify the time period for the accounting starting on April 14, 2003. Accounting requests may not be made for periods of time in excess of six (6) years. Provider will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

Right to a Paper Copy of this Notice. You or your representative have a right to a separate paper copy of this Notice at any time even if you or your representative have received this Notice previously. To obtain a separate paper copy, please contact Debbie Kravick, Office Manager, at 608-752-7255.

DUTIES OF ASSOCIATES IN PSYCHOTHERAPY

Provider is required by law to maintain the privacy of your health information and to provide you and your representative this Notice of its duties and privacy practices. Provider is required to abide by the terms of this Notice as may be amended from time to time. Provider reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all health information that it maintains. If Provider makes a material change to this Notice, Provider will provide a copy of the revised Notice to your or your appointed representative. You or your representative have the right to express complaints to Provider and to the Secretary of Health and Human Services, if you or your representative believe that your privacy rights have been violated. Provider encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

Provider has designated Debbie Kravick, Office Manager, as its contact person for all issues regarding patient privacy and your rights under the Federal privacy standards. If you have any questions regarding this Notice, you may contact this person at Associates in Psychotherapy, 4700 Dresser Dr., Ste. 100, Janesville, WI 53546, at 608-752-7255.

EFFECTIVE DATE

This Notice is effective January 1, 2003.