Ohio Apex Adolescent (Ages 14 to 17) Patient Packet

Date_____

Who referred you or how did you hear about the office?_____

Patient Name_____

Birth Date_____ **Age**_____ **Gender: Female Male Transgendered**

Social Security Number_____

Relationship Status: Single Married Separated Divorced Widowed Partnered

Home Street Address_____

City_____ **State**_____ **Zip Code**_____

Cell Phone_____

May we leave a message on your cell? Yes No

May we text appointment reminders? Yes No

Home Phone_____

May we leave a message at home? Yes No

Email_____

May we send appointment reminders via email? Yes No

Emergency Contact Name _____**Relationship**_____

Emergency Contact's Phone Number_____

Patient's Primary Care Doctor/Pediatrician's Name__

Insurance Information

If you are not the policy owner, please fill the information below:

Policy Holder's Name_____

Policy Holder's Birth Date_____

Relationship to Policy Holder_____

Sponsor's Social Security Number Needed for Tricare_____

Patient's Social Security Number Needed for Champ VA Benefits_____

I understand that if I am not the policy holder that explanation of benefits may be sent to the policy holder's address by the insurance company ____ (patient's initials).

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Responsible Party for Payment of Services (if not yourself)

Name_____

Relationship to Patient_____

Address_____

City_____**State**_____**Zip**_____**Phone**_____

I understand that statements will be sent to the above address _____ (patient's initials).

If under 18, Please complete Parent and Guardian Section Below

Mother or Guardian's Name_____

Mother Home Street Address_____

City_____ **State**_____ **Zip Code**_____

Does the patient live with this person? Yes or No

Cell Phone_____

May we leave a message on your cell? Yes No

May we text appointment reminders? Yes No

Home Phone_____

May we leave a message at home or work? Yes No

Email_____

May we send appointment reminders via email? Yes No

Father _____

Father's Home Street Address_____

City_____ **State**_____ **Zip Code**_____

Does the patient live with this person? Yes or No

Cell Phone_____

May we leave a message on your cell? Yes No

May we text appointment reminders? Yes No

Home Phone_____

May we leave a message at home? Yes No

Email_____

May we send appointment reminders via email? Yes No

The Patient's School's Name_____

School Address_____

City_____State_____Zip_____Phone_____

Grade_____

Teacher's Name_____

Ohio Adolescent Informed Consent Form

THERAPY AND CONFIDENTIALITY

The purpose of meeting with a therapist is to get help with problems in your life and/or work on problems that may be keeping you from being successful in important areas of life. You may be here because you wanted to talk to a therapist about these problems or because your parent(s), guardian, teacher(s), doctor or someone else had concerns about you. You will discuss these problems with your therapist when you meet with him or her. Your therapist will ask questions, listen to you, and suggest strategies to help you with your problems. Therapy involves getting to know your thoughts, understanding your difficulties, and coming up with better ways to cope with your problems. It is important that you feel comfortable talking to your therapist about problems that are bothering you.

Sometimes you may want to talk about things that you do not want your parent(s)/guardian to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their therapist. As a teenager, you have certain rights to privacy that are not equal to those of an adult, but privacy, also called confidentiality, are an important and necessary part of good therapy.

As a general rule, your therapist will keep information you share in therapy sessions private, unless your parent(s)/guardian give approval (consent) to share certain information. However, there are exceptions to this rule that are important for you to understand before you share personal information with your therapist. In some situations, your therapist is required by law or professional guidelines to share information even if your parent(s)/guardian do not give permission. Some of those situations are described below.

YOUR PRIVACY CANNOT BE KEPT

1. If you report having a plan to cause serious harm or death to yourself and your therapist believes you have the intent and ability to carry out this threat in the very near future. Your therapist must take steps to inform your parent(s)/guardian of what you told them and how serious they believe this threat to be and your therapist may seek hospitalization for you. Your therapist must make sure you are protected from harming yourself.

2. If you report having a plan to cause serious harm or death to someone else and your therapist believes you have the intent and ability to carry out this threat in the very near

future. In this situation, your therapist must inform your parent, guardian, or law enforcement, and your therapist must inform the person who you intend to harm.

3. If you are involved in activities that could cause serious harm to you or someone else, even if you do not intend to harm yourself or someone else. In these situations, your therapist will use his/her professional judgment to decide whether a parent, guardian, or law enforcement should be informed.

4. If you report that you are being abused or that you have been abused in the past, the law requires that your therapist report this abuse to the Ohio Office of Families and Children at the Department of Jobs and Family Services.

5. If you are involved in a court case and a request is made for information about your treatment with your therapist, your therapist will not disclose your treatment information unless the court orders that information be provided to them. If the court would order your treatment information, your therapist will do all that he or she can to protect your privacy and your therapist will inform your parent(s)/guardian that he or she is being required to share this information with the court.

6. If your parent(s)/guardian agree that information can be shared with a specific person or organization, then your therapist will discuss what information will be shared and how that information will be shared.

COMMUNICATING WITH YOUR PARENT(S)/GUARDIAN

Except for situations as described above, your parent(s)/guardian will not be told of specific information you talk about in therapy. This includes activities and behavior that your parents/guardian would not approve of or be upset by unless your behaviors are putting you or others at serious risk for immediate harm. If your risk-taking behavior becomes more serious, then your therapist will use their professional judgment to decide whether you are in serious and immediate danger of being harmed. If your therapist believes you are in such danger, your therapist will communicate this information to your parent(s)/guardian.

Even if your therapist has agreed to keep information private, your therapist may believe that it is important for your parent(s)/guardian to know what is going on in your life. In these situations, your therapist will encourage you to tell your parent(s)/guardian and your therapist will help you find the best way to tell them. Also, when meeting with your parent(s)/guardian, your therapist may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

COMMUNICATING WITH SCHOOLS AND TEACHERS

Your therapist will not share information with your school unless your parent(s)/guardian give permission. Sometimes your therapist may request to speak to someone at your

school to find out how things are going for you. Also, it may be helpful in some situations for your therapist to give suggestions to your teacher or counselor at school. If your therapist wants to contact your school, or if someone at your school wants to contact your therapist, your therapist will discuss it with your parent(s)/guardian and ask for their written permission. A very unlikely situation might come up in which your therapist does not have your parent(s)/guardian permission to talk with them but your therapist believes that it is very important for them to share certain information with someone at your school. In this situation, your therapist will use his/her professional judgment to decide whether to share any information.

COMMUNICATING WITH PHYSICIANS/DOCTOR'S OFFICES

Sometimes your doctor and your therapist may need to work together as your doctor may have been involved in referring you for therapy, your doctor may have prescribed medication for you, or your doctor may be considering prescribing medication for you. Your therapist will get written permission from your parent(s)/guardian in advance to share information with your doctor. The only time your therapist will share information with your doctor even if your therapist does not have your parent(s)/guardian permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

COURT PROCEEDINGS

Your parent(s)/guardian agree that your therapist's role is limited to providing treatment and that your parent(s)/guardian will not involve your adolescent's therapist in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.). Your parent(s)/guardian agree that you will not ask your adolescent's therapist to testify in court, whether in person, or by affidavit. Your parent(s)/guardian agree to instruct your attorneys not to subpoena your adolescent's therapist. In addition, your parent(s)/guardian agree to not have your attorney refer in any court filing to anything your adolescent's therapist may have said or done.

PARENTAL CONSENT FORM

I (We) voluntarily consent to psychological treatment for my (our) child by a behavioral health clinician at Apex Psychological Care and Memory Center.

I (We) understand that, as an adjunct to my (our) child's treatment at Apex Psychological Care and Memory Center, I (we) may be asked to participate in treatment.

I (We) understand that I (we) retain responsibility for my (our) child while he/she is in treatment at Apex Psychological Care and Memory Center.

I (We) understand that in the event of an emergency situation, as determined by the staff of Apex Psychological Care and Memory Center, I (we) am (are) expected to respond promptly to requests for assistance from the staff.

I (We) understand and agree that should I (we) be unable, for any reason, to respond to such a request, Apex Psychological Care and Memory Center should and will take whatever steps the staff deems necessary and appropriate to resolve the situation.

I (We) understand that, in situations where relevant, the non-custodial parent has legal access to clinical records of Apex Psychological Care and Memory Center, without the custodial parent's consent.

I (We) agree that my (our) child's clinician's role is limited to providing treatment and that I (we) will not involve my (our) child's clinician in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.).

I (We) agree that I (we) will not ask my (our) child's clinician to testify in court, whether in person, or by affidavit.

I (We) agree to instruct my (our) attorney(s) not to subpoena my (our) child's clinician or to refer in any court filing to anything my (our) child's clinician may have said or done.

I (We) have read the confidentiality agreement included in this packet.

FIRST SESSION

Your first session will involve an evaluation of your needs. Your clinician will meet with you for no longer than 45 minutes and sessions must end promptly. During this time, you can decide if your clinician is the best person to provide the services you need. By the end of the evaluation, your clinician will discuss your preliminary diagnosis and treatment recommendations. You should evaluate this information along with your own opinions of whether you feel comfortable working with your clinician. If you have questions about the process, please feel free to ask your clinician whenever they arise. Your clinician will be happy to refer you to another mental health professional for a second opinion or other treatment if necessary.

NEUROPSYCHOLOGICAL/PSYCHOLOGICAL TESTING

Neuropsychological or psychological testing uses various tests to assess your thinking and behavior in order to aid in your diagnosis. Neuropsychological or psychological testing involves you taking many different kinds of tests that your psychologist will administer. Your psychologist may assess your behavior and abilities to: pay attention, learn and remember information, reason, perceive information, problem solve, use language, organize and plan information, and motor speed. Your psychologist will score all your tests and then compare your results to individuals who are similar to you to determine whether or not you have a memory disorder, thinking disorder, or a behavioral problem. Neuropsychological/Psychological test reports will only be released to other parties with your permission when your balance is paid in full.

MINORS

If you are under eighteen years of age, please be aware that the law states that your parents have the right to examine your treatment records unless a court determines that it is not in their best interest.

PSYCHOTHERAPY TREATMENT

If you decide to pursue psychotherapy with your clinician, he or she will typically schedule one session on a weekly basis until you start feeling better. Your clinician will taper/space sessions apart after you see improvement in your symptoms. Sessions last no longer than 45 minutes and sessions must end promptly.

Psychotherapy uses many different methods to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things your clinician talks about both during your sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness at times. Psychotherapy has also been shown to have benefits for people including: building better relationships, finding solutions to specific problems, and feeling less distressed. There are no guarantees of what you will experience during psychotherapy. If you have not been seen by your clinician in the past 30 days, your case will be closed if your clinician has not already closed your case. Your case may be re-opened if your balance is paid in full and if you have not been discharged from our practice.

EMERGENCY CALLS

If a life threatening emergency occurs, please go to the local emergency room and/or call our office at 330-953-1354 (Ohio) or 724-457-0858 (Pennsylvania), where our office staff or answering service will contact your clinician and notify them of your situation. If you are unable to get in contact with your clinician, then go directly to your local emergency room. For non-life threatening situations, please try to discuss these situations with your clinician during your scheduled visit. If your clinician is not in the office, your phone call may be returned by another clinician. This clinician may not know your case, but they will make every effort to be helpful in your clinician's absence.

SCHEDULING APPOINTMENTS

Please call our office at 330-953-1354 (Ohio) or 724-457-0858 (Pennsylvania) to schedule an appointment. If you did not pay your share of healthcare costs (e.g., copay, coinsurance, or deductible), you will not be allowed to schedule a future appointment(s) until your balance is paid in full unless a payment plan is agreed upon. If you do not show for an appointment or provide at least 24 hour notice when cancelling an appointment, you will be required to pay a $50 fee. The no show or late cancellation fee must be paid and/or a payment plan must be agreed upon in order for future appointments to be scheduled. If another appointment has been previously scheduled, this appointment may be cancelled if you have an outstanding balance unless a payment plan is agreed upon.

PROFESSIONAL RECORDS

The laws and standards of your clinician's profession require that they keep mental health treatment records. You are entitled to receive a copy of your record unless your clinician believes that seeing them would be emotionally damaging. Your mental health record can be misinterpreted and/or upsetting to untrained readers. Therefore, it is recommended that if you choose to view your mental health record that you review them in the presence of your clinician so that he or she can discuss the contents and answer any questions you may have. You will be charged an appropriate fee for copying your records and any time spent in preparing information requests (see financial policy section).

BEING DISCHARGED FROM TREATMENT

Your case will be closed and you will have to find another provider if you have three (3) no show and/or late cancellation appointments or if you have a past due balance with no payment being made to your account in 60 days. We will gladly assist you in finding another provider if the above situation(s) should arise.

ELECTRONIC COMMUNICATION POLICY

This outlines our office policies related to the use of electronic communications. Our electronic communications policy will hopefully assist you in understanding how our clinicians and office staff interact with patients through electronic communications methods. Please be aware that email, text, and social media communications are generally not secure means of communication and can be easily accessed by unauthorized people. Therefore, the confidentiality of email, text, and social media communications is not guaranteed.

If you have any questions about anything within this document, our office encourages you to discuss these questions with your clinician.

EMAIL COMMUNICATIONS

Email communications are generally not secure means of communication and can be easily accessed by unauthorized people. Therefore, the confidentiality of email communications is not guaranteed. Email appointment reminders may be given if you elect to receive this type of reminder. If you choose to contact our office through email, our office staff and clinicians will only respond to emails for administrative purposes such as changing appointments, billing matters, and other administrative related matters. Please do not email your clinician about personal matters as email communications are not secure ways to contact your clinician. Please call the office to set up an appointment with your clinician to discuss personal matters.

TEXT MESSAGING

Because text messaging is another unsecure mode of communication. Text appointment reminders may be given if you elect to receive this type of reminder. Our office staff and clinicians will not have the capability to respond back to texts. Please do not text your clinician about personal matters as text communications are not secure ways to contact

your clinician. Please call the office to set up an appointment with your clinician to discuss personal matters.

SOCIAL MEDIA

Our staff and clinicians do not accept friend or contact requests from current or former patients on social networking sites. Our staff and clinicians do not communicate with, or contact, any of our patients through social media platforms like Twitter, Facebook, Instragram, LinkedIn, etc. In addition, if our staff and/or clinicians discover that they have accidentally established an online relationship with a patient or former patient, our staff or clinician will cancel that relationship on the social networking site. Our office believes that adding patients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. Please do not try to contact staff or clinicians through their personal social media networking site(s). Our staff and clinicians will not respond to any contact through their personal social media networking site(s).

WEBSITE

Our office has a website (www.apexpsychcare.com) that you are free to access to obtain information about our practice.

FINANCIAL POLICY

INSURANCE PLANS ACCEPTED

We accept most insurance plans. We will do the best to help you interpret your health care benefits, but it is ultimately your responsibility to understand which services are covered and which are not covered under your plan. In some cases, insurance companies require pre-authorization prior to seeking treatment. We will attempt to obtain the authorization for you; however, some insurance companies require that you obtain your own authorization. Claims will be paid at the contracted rate that Apex has with your insurance company. You are responsible for copay/coinsurance, deductible payments, and claims or fees that your insurance company does not cover.

FEES THAT INSURANCE COMPANIES DO NOT COVER

No Show/Late Cancellation Fee	$50.00
Telephone Conversations from 15 minutes to 30 minutes	$86.00
Telephone Conversations from 31 minutes to 1 hour	$142.00
Medical Forms to Complete	$30.00 for every 4 pages
Copying of medical records	$25.00
Narrative Reports	$180.00 each
Meetings with other professionals per your request	$180.00 per hour
Returned Check Fee	$25.00 per check

PRIVATE PAY RATES FOR THOSE WHO DO NOT HAVE INSURANCE

Initial Evaluation	$215.00
45 minute psychotherapy session	$142.00
30 minute psychotherapy session	$86.00
Neuropsychological/Psychological Testing	$180.00 per hour*

*Neuropsychological/Psychological/Testing includes: testing time, scoring, and report writing.

A discount of 25% for doctoral level practitioner services and 40% for master level practitioner services will be given when you pay at the date of service.

Please note: Account balances must be paid in full for our office to send records/reports to other professionals with your permission.

NO SHOW/LATE CANCELLATION FEE

If you do not show for an appointment or provide at least 24 hour notice when cancelling an appointment, you will be required to pay a $50 fee. This fee must be paid and/or a payment plan must be agreed upon in order for future appointments to be scheduled. If another appointment has been previously scheduled, this appointment may be cancelled if the fee has not been paid.

LEGAL PROCEEDINGS THAT REQUIRE YOUR CLINICIAN'S PARTICIPATION

You will be expected to pay for your clinician's professional time even if your clinician is called to testify by another party. We charge $360.00 for the first hour (one hour minimum) and $180.00 for each hour thereafter for preparation and attendance at any legal proceeding. If the clinician is required to travel 50 miles or more from Apex, you will be charged a mileage fee at the Internal Revenue Rate for any miles after the first 50 miles.

BILLING AND PAYMENTS

You will be expected to pay for each session or pay your copay/coinsurance/deductible on the appointment date. Payment schedules for other professional services not listed above will be agreed to when they are requested. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. In addition, if you have an account balance and no payments have been made in 60 days, then you will be discharged from our practice.

BILLING YOUR INSURANCE

We will bill your insurance company and will provide them with a clinical diagnosis(es), dates of service, and type of service performed. Sometimes we have to provide additional clinical information such as treatment plans/summaries or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, we have no control over what they do with your information once they receive it. In some cases, they may share the information with a national medical information databank.

Ohio Confidentiality Agreement

In general, the privacy of all communications between a patient and a mental health professional is protected by law, and we can only release information about the content of your sessions/evaluations to others with your permission. **However, there are a few exceptions below:**

1) If you threaten to harm yourself, we are obligated to seek hospitalization for you or contact your family members or others who can help provide protection for you.

2) If you threaten serious bodily harm to another individual(s), we are required to take protective actions. These actions may include: notifying the potential victim(s), contacting the police or other authorities, or seek hospitalization for you.

3) If you are under the age of 18 (or under the age of 21 if you are mentally retarded, developmentally disabled, or physically impaired), we are required to report to authorities if you are being abused (emotionally, physically, or being neglected) or if you are facing the threat of being abused.

4) If the court orders (not subpoenas) your medical record, we will have to relinquish your records to the court. However, we will attempt to discourage the court from doing this. If you file a lawsuit against our office or file a complaint with the state licensing board, we will be required to release your medical records to the lawyers and/or licensing board.

5) If you are using insurance or another third party payer, our office must share certain information with them, including, but not limited to: diagnosis(es), the dates of your visits, symptoms, treatment progress, and occasionally your treatment notes.

6) The confidentiality of email and text communications is not guaranteed as these are not secure modes of communication.

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 INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. This federal law is called the Health Insurance Portability and Accountability Act of 1996 (HIPPA). HIPPA requires our office to keep your protected health information private and to give you this notice about our legal duties and privacy practices. Our office will obey the rules described in this notice.

Every time you visit a health care provider, hospital, or clinic, information is collected about you and your physical and mental health. It may be information about your past, present, or future health, medical conditions, tests, and/or treatments you received from our providers or others, demographic

information, or about payment for health care. This information we collect from you is called "Protected Health Information (PHI)."

After you have read this notice, you will be asked to sign a separate authorization form to allow us to share your PHI. In addition, your provider may have notes about your sessions which are called psychotherapy notes and these are kept separate from the medical record. You must sign a written authorization to release your psychotherapy notes. In order to administer our services effectively, we will collect, use and disclose your PHI for treatment, payment for health care services, and health care operations. If we use your PHI for other purposes, we must tell you about them and ask you to sign a written authorization. HIPPA law also says that there are some uses and disclosures that do not need your consent or authorization.

HOW WE USE AND DISCLOSE YOUR PHI WITH YOUR CONSENT

Treatment We will use and disclose your PHI to provide and coordinate your health care and any related services. We may also share your PHI with other past, present, or future health care providers. These providers may include your primary care physician, psychiatrist, treatment team, or other health care professional. For example, we may discuss your diagnosis with your primary care doctor who may prescribe medication to help with your health issue.

Payment for Health Care Service We may use and disclose PHI about you for the purpose of determining coverage, billing, claims management, medical data processing, and reimbursement. Your PHI may be released to an insurance company or a third party payer, or its agent. For example, we may contact your insurance company to determine what treatments your insurance covers.

DISCLOSING YOUR HEALTH INFORMATION WITHOUT YOUR CONSENT

For Health Care Operations We may use and disclose PHI about you in order to support quality improvement and other business activities of our organization. These uses and disclosures are necessary for our operations and ensure the quality of care received by our patients. For example, we may use your PHI to see where we can make improvements in the care and services we provide.

Business Associates We hire other businesses to do work for us and they are called "business associates." For example, these individuals may process claims or answer our phones after hours. These business associates need some of your PHI to do their job properly. To protect your privacy, they have agreed in their contract with us to safeguard your PHI.

Required by Law/Public Health Activities We have to disclose some PHI to the government agencies that monitor our obeyance of the privacy laws. We may use or disclose your PHI to the full extent that public health activities are permitted by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability.

Abuse or Neglect We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence.

Legal Proceedings We may disclose your PHI: 1) in the course of any judicial or administrative proceeding; 2) in response to an order of a court or administrative tribunal; and 3) in response to a subpoena, a discovery request, or other lawful process. We may disclose your PHI to: 1) any law enforcement required for legal process; or 2) if it is necessary to locate or identify a suspect, fugitive, material witness, or missing person.

Serious Health Threats Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Workers' Compensation We may disclose your PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries, illnesses, or payment for such services.

U.S. Department of Health and Human Services (HHS) We may disclose your PHI to demonstrate HIPPA compliance.

Specialized Government Functions We may disclose your PHI for specialized government functions (e.g., fitness for military duty, eligibility for VA benefits, or national security and intelligence etc.).

Others Involved In Your Health Care We may disclose some of your PHI with your friend, family member, or responsible party (e.g., power of attorney or guardian) that you have identified as being involved in your health care. We may disclose some of your PHI to your parents or legal guardians. We may also disclose your PHI to an entity in a disaster relief effort so that your family or guardian can be notified about your condition, status, or location. If it is an emergency and you are not present or able to agree to these disclosures then we may, use our professional judgment to determine whether the disclosure is in your best interest and hence we may disclose some of your PHI to the aforementioned individuals or agencies.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right To Access You have the right to examine or get copies of your PHI in a designated record set either in paper or electronic format. In addition, you have a right to designate a third party who may receive your PHI in a designated record set either in paper or electronic format through a written authorization. A record set contains psychological, medical, and billing records, as well as records of decisions made about your health care. *The actual test forms used in neuropsychological testing will not be released. Your psychotherapy notes (if your provider kept these notes), which are separate from your medical record, will not be released.* Any request must be made in writing to obtain PHI. We may charge you to get a copy of your records. We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied, you have the right to a review. A licensed professional health care provider, chosen by us, will review your request and the denial. Under certain circumstances, our denial will not be reviewable. If this event occurs, we will inform you that our denial is not reviewable.

Right To Amend Your PHI If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions, but not deletions, to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reason(s) you want to make the change(s).

Right To Restriction You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment, or other health care operations. We are not required to agree with these restrictions, but if we do, we will abide by our agreement unless the PHI is needed to provide emergency treatment to you. Any agreement of restrictions will be in writing and signed by you or your legal guardian. You have the right to restrict certain disclosures of PHI to an insurance company when you pay out-of-pocket in full for our services.

Right To Request Confidential Communications You have the right to request that we communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you may ask that we contact you only at your home phone number, but not your cell phone number. You must make your request in writing and you must also give alternative ways of communication of your PHI.

Right To File A Complaint You have the right to file a complaint if you believe that your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

Right to Be Notified if There is a Breach of Your PHI You have the right to be notified if there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; if your PHI has not been encrypted to government standards or if our risk assessment shows there is a probability that your PHI has been compromised. In addition, HHS will also be notified of this breach.

Right To A Copy Of This Notice You have a right to a copy of this notice. We have the right to change the terms of this notice. If we change this privacy notice, we will post the new privacy notice in our waiting room.

HOW WE PROTECT INFORMATION

We restrict access to our patient's PHI to those employees, agents, third party billing services, consultants, or other health care providers or health care services. We maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to guard personal financial information from unauthorized access, use and disclosure**.**

For questions about this Privacy Notice and/or if we change our Privacy Notice policies you can get a copy from our privacy officer, Gigi, who can be reached at 330-599-5828.

The effective date of this notice is January 1, 2018.

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

When we examine, test, diagnose, treat, or refer you, we will be collecting what the HIPPA privacy law calls, "Protected Health Information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although, we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. You have the right to revoke your consent to our privacy practices by writing your revocation to our privacy officer. We will then stop using or sharing your PHI, but we may have already used or shared some of it, and we cannot change that.

I am the legal authorized individual to consent to treatment and to make medical decisions for my minor child. I voluntarily consent to evaluation and treatment by a clinician at Apex for my minor child. I acknowledge that no guarantees have been made to me as to the result of this evaluation or subsequent treatments. My signature below acknowledges that I have read or heard our notice of privacy practices and agree to let us use you and your minor child's PHI and to send it out to others for the purposes described in our Notice of Privacy Practices. My signature below means that I understand and agree with all of the terms that are in this agreement.

Please note if there is a **shared or joint custody agreement for medical decisions for the minor child**, then both parents must consent to treatment for the minor child **and both parents must sign this agreement in order for the minor child to be seen by a clinician.** In addition, **those with custody agreements for medical decisions, guardianships, and/or Power of Attorneys must provide a copy of the legal documentation** of the custody agreement, guardianship, and/or Power of Attorney document in order to sign this agreement and in order for the minor child to be seen.

Name of Minor _____ **Date** _____

Signature of Adolescent_____ **Date**_____

Signature of Parent or Guardian _____ **Date**_____

Signature of Parent or Guardian _____ **Date**_____

Witness _____ **Date**_____