AGREEMENT FOR PSYCHOLOGY SERVICES

Welcome to the office of Dr. Allison Hanauer! This document contains important information about Dr. Hanauer’s professional services and business policies. Please read through this carefully before your first appointment and initial and sign where indicated below. When you sign this document, it will constitute an agreement between you and Allison C. Hanauer PhD, LLC. If treatment is conjoint (couple or family), all adults must sign this document for confidentiality and other purposes.

1. CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (the client’s) written permission, except as provided in this agreement:

   ◆ When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a patient presents a danger to self, to others, to property, or if a patient is gravely disabled.

      Initial here: _____

   ◆ When Disclosure May Be Required: Disclosure may be required as a result of a judicial or administrative proceeding. If your mental status is at issue in any such proceeding, other parties may have the right to obtain your psychotherapy records and/or testimony from Dr. Hanauer or the results of a forensic or court-ordered evaluation. In addition, in couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Unless required to do so in the course of a legal proceeding or as otherwise required by law, Dr. Hanauer will not release records to any outside party unless she is authorized to do so by all adult family members who were part of the treatment.

      Initial here: _____

   ◆ Coordination of Care with Primary Care Provider: Research has shown that communication between psychological providers and clients’ primary care managers (PCMs) can lead to greater and more rapid treatment gains as well as increased personal safety on the part of the client. Dr. Hanauer encourages communication of diagnosis and/or brief treatment summaries and updates to the primary care manager, but this is not mandatory. By initialing below and providing the name and phone number of your PCM, you are giving Dr. Hanauer permission to send limited information to your PCM for coordination of care.

      Initial here: _______ Name of PCM: ___________________ Phone number of PCM: ______________

   ◆ Staff: Dr. Hanauer may need to share protected information with others employed by her practice such as administrative staff for administrative purposes or another licensed professional for a review of records for quality purposes. All employees are properly trained to protect your privacy and will not release your confidential information other than as permitted by this agreement.

      Initial here: _______

   ◆ Telephone, Electronic and Mail Contact: You acknowledge the risks of inadvertent disclosure outlined in Section 3 below.

      Initial here: ______

   ◆ Insurance Companies: By signing this agreement, you are consenting to a release of information about your case to your health plan for claims, certification and case management for the purposes of treatment and payment. Dr. Hanauer has no control or knowledge over what insurance companies do with the information that is submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance.

      Initial here: ______

   ◆ HIPAA: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that is designed to protect the privacy of patient information, provide for the electronic and physical security of health and patient medical information,
and simplify billing and other electronic transactions by standardizing codes and procedures. The HIPAA Privacy Rule creates a minimum federal standard for the use and disclosure of Protected Health Information (PHI) by health care organizations. One of the requirements of the Privacy Rule is that we give to you a Notice of Privacy Practices (NPP) that describes your rights and protections regarding your health care records (PHI). You will find this Notice of Privacy Practices at then end of this packet as well as on our website, www.allisonhanauer.com. In our Notice of Privacy Practices we include other circumstances, in addition to those included this Section 1, in which we may disclose your confidential information. All of those circumstances are incorporated herein by reference. Please review the Notice of Privacy Practices carefully for a complete list.

I have reviewed and understand Allison C Hanauer PhD LLC’s confidentiality policy, including as set forth in her HIPAA policies- Notice of Privacy Practices, and have been made aware of how my records may be used and disclosed.

Signature of Client/Responsible Party                                      Print Name                                      Date

2. TELEPHONE & EMERGENCY PROCEDURES:

❖ The best phone number to reach Dr. Hanauer is (901) 302-6620. If you reach the voice mail, please leave a message. Dr. Hanauer may be on the phone, in therapy with someone else, or out of the office.

❖ In a crisis, if Dr. Hanauer cannot be reached and you are in imminent danger, call the police (911), or go immediately to your local emergency room. In addition, Lakeside Behavioral Health has a 24/7 free assessment service. Their number is (901) 377-4733.

❖ If there is an emergency whereby Dr. Hanauer becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, Dr. Hanauer will do whatever she can within the limits of the law, to prevent you from injuring yourself or others; and to ensure that you receive the proper medical care. For this purpose, Dr. Hanauer may also contact the person whose name you have provided as an Emergency Contact on the Intake Form.

Initial here: ________

3. INFORMED CONSENT FOR TELEPHONE, ELECTRONIC, AND MAIL CONTACT:

Ordinary privacy precautions such as voice scramblers, pin codes, voice mail boxes, and locked fax, mail, and computer rooms are by no means foolproof. In addition, deletion or shredding of private material is not a totally safe means of disposal, so that you are always at risk of breaches in confidentiality when electronic or mail communication of any type is used for private information. Your use of such means of communication constitutes implied consent for reciprocal use of electronic and mail communication as well. By signing this contract, you agree to and understand the following:

❖ There is no guarantee that antivirus and similar programs will work 100%.

❖ Sent and received emails are stored on both Dr. Hanauer’s e-mail account and your computer until deleted. Any saved emails on Dr. Hanauer’s computer will be kept in a password-protected account that only Dr. Hanauer has access to.

❖ In addition, whenever you send an email, it is stored in cyberspace. It is possible for authorities to locate and read such emails under various circumstances; this is not a policy of Dr. Hanauer, but is due to the nature in which email is transmitted using the Internet.

❖ By initialing below, I agree that I understand the disclosures listed above regarding communicating with Dr. Hanauer using email. I also agree that if I send an email to Dr. Hanauer and request a response via email, that I am willing to accept the above-stated risks. I also agree that I will not use email for emergencies.

Initial here: ________

Permission for Dr. Hanauer to initiate emails to you:

Initial below if you give your permission for Dr. Hanauer to initiate sending emails to you.

Initial here: ________
Print your email clearly: ____________________________

Permission for Dr. Hanauer to initiate text message appointment reminders to you:

Many clients find text message appointment reminders to be very helpful. Dr. Hanauer uses a HIPAA compliant electronic medical records and appointment scheduling system that is capable of sending you text message appointment reminders. It is up to you to determine passwords as well as privacy settings on your cell phone that either allow or do not allow previews of any text message sent to you from being seen on your phone prior to your logging in to the phone. Initial below if you give your permission for Dr. Hanauer to send you text message appointment reminders.

Initial here: ________  
Print your cell phone number clearly: __________________________________________________________

4. CONSENT TO TREATMENT:

I, (print name of responsible party) _______________________________ consent for treatment to be rendered by Allison C. Hanauer, PhD., Clinical Psychologist. I grant Dr. Hanauer permission to perform those procedures and treatments, which may include professional consultation or emergency telephone responses, necessary for my condition that are generally used in this and similar settings.

Signature of Client/Responsible Party  Print Name  Date

5. APPOINTMENTS:  All office visits are by appointment and may be scheduled through Dr. Hanauer.  Because consistency is an important part of the treatment process, the appointment time you schedule is reserved for you and is not available to anyone else.  Please arrive on time, as you use up your own time when you arrive late for an appointment.  The usual length of an appointment is 50 minutes.

Cancellation Policies: Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice (to include one business day) is required for rescheduling or canceling an appointment.  You will be charged $50 without such notification.  Most insurance companies do not reimburse for missed sessions.  You are individually responsible for paying this fee.  Medical emergencies will be considered on a case by case basis with documentation of treatment.  

Your compliance in keeping appointments and active participation in treatment is vital.

Initial here: ________

6. PAYMENT & INSURANCE REIMBURSEMENT:

- Clients paying on a cash basis, and not billing any insurance company are expected to pay in full at time of service unless other arrangements have been made.
- Except in the case of minors or when other arrangements are made, the person receiving the psychological service is financially liable.
- Insured clients are expected to take care of their fees as services are rendered.  Your health insurance may help you recover some of your treatment costs.  Most group policies, but few individual policies, cover outpatient psychotherapy.  Please verify with your company the amounts of coverage for outpatient psychotherapy.  If your policy requires pre-authorization to receive services, this is your responsibility and needs to be handled before your first visit.
- Our office will bill your insurance company for services provided.  You will receive a statement each month reflecting any balance due on your account.  You are responsible for your co-pays and paying your insurance company’s contracted rates until your deductible is met (if applicable) at the time of each appointment.  You assign to me all insurance benefits due to you to the full extent of your financial obligation to our office.
- The client portion (co-pay) of fees is expected at the time of service.  Co-pays are not negotiable.  Failure to pay your part may jeopardize your benefits.
- Additional fees are charged for lengthy telephone communications, court attendance, attendance at school individual education plan meetings (IEP) and some types of report/letter writing.  Insurance does not cover these services.
- There is a $30.00 service fee for checks returned for non-sufficient funds, and the client will be required to pay for future
sessions in cash or credit card. Before any future visits occur, the client or responsible party must pay in cash the service charge PLUS the value of the check. In addition, an administrative re-billing fee may be charged on unpaid bills.

- At any time during treatment should the client become ineligible for insurance coverage, the client and/or responsible party agrees to notify Dr. Hanauer and will be responsible for 100% of the bill not covered by insurance.

Initial here: ________

Collection Policy: This office reserves the right to refer delinquent accounts to a professional collection agency. If it becomes necessary to transfer your account to a collection agency, your financial records will be released to them and your delinquent balance will be recorded with the three (3) major credit bureaus, i.e., Trans Union, Equifax, and Experian.

- Accounts become delinquent after thirty (30) days. A 12% fee will be added for balances over 30 days old.
- If legal proceedings become necessary to collect an unpaid debt, the client hereby agrees to bear all financial responsibility for all costs of collection, including reasonable attorney’s fees and all court costs associated with collecting the debt. Please be aware that we take this action only as a last resort.

Initial here: ________

Insurance Appeals and Grievances: I acknowledge my right to request reconsideration (an Appeal) in the case that client care is not certified by my insurance company. I understand that I would request an appeal directly through my insurance company.

I understand that the Tennessee Department of Consumer Affairs is responsible for regulating health insurance services. The office of Consumer Insurance Services has a toll-free telephone number (800-342-4029) to receive complaints regarding health care plans. If I have a grievance about an appeal that has not been satisfactorily resolved by the plan I can contact this hotline.

Initial here: ________

Consent Regarding Responsibility for Payment Pending Insurance Authorization: By signing this agreement, you agree that if you have not obtained any necessary authorizations from your insurance, or are not eligible at the time services are rendered, you are responsible for payment even if the determination is made after the services are rendered. Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance company.

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7. THE PROCESS OF THERAPY/EVALUATION: By signing this agreement you are authorizing and requesting that Dr Hanauer carry out psychological treatment and/or diagnostic procedures that now or during the course of your care as a client are advisable. Participation in therapy can result in a number of benefits, including improved interpersonal relationships and resolution of the specific concerns that led you to seek therapy.

Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Dr. Hanauer will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended. Sometimes another family member views a decision that is positive for one family member negatively. Change may be swift or slow. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, Dr. Hanauer is likely to draw on various psychological approaches based on an assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive-behavioral, rational emotive, interpersonal, systems/family, cognitive processing therapy, prolonged exposure therapy, eye movement desensitization and reprocessing (EMDR), developmental (adult, child, family), or psycho-educational.

- I understand that if I am concerned about slow progress or lack of progress I have the right to speak about my concerns.
- I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality.
I understand that if I have been referred by a court or state agency, I have the right to divulge only what I want to be included in a report.

- I understand that I have the right to have my questions about diagnosis, treatment plan and treatment progress answered.

- I understand that there are some occasions when confidentiality can/must be breached. These are described in Section 1 above and in the Notice of Privacy Practices, attached.

- I understand that I have the right to ask about other treatments for my condition and their risks and benefits. If I could benefit from any treatment that Dr. Hanauer does not provide, Dr. Hanauer has an ethical obligation to assist me in obtaining those treatments.

- I understand that Dr. Hanauer is not a psychiatrist, and as such cannot recommend or prescribe medications but can encourage clients to see an M.D. for a medical evaluation.

Initial here: ______

8. PROFESSIONAL RECORDS: The laws and standards of the profession require that Dr. Hanauer keep treatment records. You are entitled to receive a copy of your records, or Dr. Hanauer can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, Dr. Hanauer prefers that you review them in her presence so that she can discuss the contents and answer any questions you may have. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

Initial here: ______

9. TERMINATION:

- You have the right to terminate therapy at any time. A final closure session has proven to be very beneficial for clients and is strongly recommended. Closure sessions help you acknowledge and summarize what you have accomplished and discuss any unfinished concerns you may have. If at any point during psychotherapy, Dr. Hanauer assesses that she is not effective in helping you reach the therapeutic goals, she is obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case, Dr. Hanauer would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, Dr. Hanauer will talk to the psychotherapist of your choice in order to help with the transition.

- If at any time you want another professional’s opinion or wish to consult with another therapist, Dr. Hanauer will assist you in finding someone qualified, and with your written consent, will provide her or him with the essential information needed.

- If you don’t show up for three consecutive scheduled appointments, your treatment will be considered canceled and terminated and you will be financially responsible for fees from the missed sessions. A letter will be sent to you acknowledging the termination along with a closing bill for any unpaid balance.

Initial here: ______

I have read the above Agreement carefully. I have discussed it with Dr. Hanauer if desired and all questions are answered to my satisfaction. I understand the contents of this Agreement and agree to comply with its terms.

Signature of Client/Legal Representative
Print Name
Date

Additional Client Signature (Spouse, Partner, Family Member)
Print Name
Date
Client Information

Client’s Name: ____________________________  Today’s Date: ________________________

(Last) (First) (Middle Initial)

Soc. Sec. #: ______________________________________________________________
(Only needed for Tricare insurance--all others may disregard)

Gender:  M     F  Age: ___ Birth date: ________________  Birth Place (City & State)

Address: ________________________________________________________________

City, State, Zip:

Home Phone __________________________________ May we leave a message at home?  Yes  No

Work Phone __________________________________ May we leave you a message at work?  Yes  No

Cell Phone __________________________________ May we leave a message on the cell?  Yes  No

E-mail __________________________________ May we email you or put you on our mailing list?  Yes  No

Responsible Party, if the client is an underage minor: Who is the legal guardian?

Name: ____________________________  Address ______________________________________

City, State & Zip __________________________________________________________

Social Security# __________________________________________  Birth date: ____________
(if Tricare insurance)

Home Phone ____________________________  Work Phone ____________________________  Cell Phone ____________________________

May we call you or leave a message for you at:  Home [ ]  Work [ ]  Your Cell [ ]

Important persons to contact in case of emergency (Please provide name and telephone number):

[ ] Spouse  [ ] Parent  [ ] Other ____________________________  #  #  #

Employment Information

Client Occupation: ____________________________  Employer: ____________________________

Employer Address, City, State, Zip Code: _______________________________________________

Phone # (_______) ____________________________  Check One:  ___Employed Full-Time  ___Employed Part-Time

___Unemployed

Others at Home

Souse, children and/or other dependents currently at home: (please provide names and ages)

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Referral By? (Check all that apply):

___ I am a former client returning. How long ago? _____  ___Family or Friend

___ Brochure/Flyers  ___ Internet  ___ Another Therapist

___ Employee Assistance Program  ___ Employer/Supervisor  ___ Colleague

___ Union Representative  ___ School

___ Insurance Company/Managed Care  ___ Physician

___ Court/Legal  ___ Other
PLEASE SIGN BELOW TO INDICATE THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT:

_______________________________________________________
Signature of Client

[ ]

_______________________________________________________
Signature of Parent/Legal Guardian/Foster Parent/Conservator/Other
(Required if participant is a minor, under age 18)

[ ]

[ ]
### INSURANCE INFORMATION

**Who Is Responsible for this account? Who is the insured? What are your insurance requirements?**

<table>
<thead>
<tr>
<th>Primary Insurance</th>
<th>Insured is:</th>
<th>Self</th>
<th>Spouse/Partner</th>
<th>Child</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of individual who holds the policy:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Birth of the primary policy holder:</td>
<td></td>
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<td></td>
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<tr>
<td>What is the insurance company name?</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Social Security Number of policy holder if Tricare:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Billing Address</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Insurance Phone Number (_________)</td>
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<tr>
<td>Is it a [ ] PPO? [ ] or HMO? [ ]</td>
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<tr>
<td>Name of individual who holds the policy:</td>
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</tr>
<tr>
<td>What is the insurance company name?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Billing Address</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone Number (_________)</td>
<td></td>
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</tr>
<tr>
<td>Is it a [ ] PPO? [ ] or HMO? [ ]</td>
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</tr>
</tbody>
</table>

**Secondary Insurance: Insured is:**

<table>
<thead>
<tr>
<th>Insured is:</th>
<th>Self</th>
<th>Spouse/Partner</th>
<th>Child</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of individual who holds the policy:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the insurance company name?</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Billing Address</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone Number (_________)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Is it a [ ] PPO? [ ] or HMO? [ ]</td>
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</tr>
</tbody>
</table>


Although **you are ultimately responsible for your fee**, health insurance may pay a portion of the charge. At your request, Dr. Hanauer will contact your insurance company to file your claims.

If your annual deductible has been met, it may be possible for you to pay only your portion of the fee and for the insurance company to pay the balance directly to the office. If the deductible has not been met, you will be responsible for paying the full fee until the deductible has been satisfied, or you may agree to a plan with the office manager for paying the deductible and co-payment amounts. **Co-pays are due at the time of your session.**

**Initial ________**

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**FOR OFFICE USE ONLY**

<table>
<thead>
<tr>
<th>Number of sessions per year:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of sessions in a lifetime:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allowable charges: $</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do they consider a parity diagnosis?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage per session: $<strong><strong><strong><strong><strong>/</strong></strong></strong></strong></strong>/________<strong>/</strong>_______/%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allowable Co-payment: $</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SOURCE: __________________ DATE: __________________ STAFF INITIALS ____________**
HIPAA Required Notice of Privacy Practices

I respect clients’ confidentiality and only release information about you in accordance with state and federal laws.

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

This notice describes my policies related to the use of the records of your care at the office of Allison C Hanauer PhD LLC. I am required to give you this Notice about (1) the use and disclosure of your health information, (2) my legal responsibilities, and (3) your rights concerning your health information and to abide by the terms of this notice.

You may request a copy of my Notice at any time. For more information about my privacy practices, or for additional information, contact Allison C Hanauer PhD LLC, 155 N Main St, Ste 102B, Collierville, TN 38017, (901) 302-6620.

1. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I use and disclose the minimum necessary health information about you for your treatment, for payment for your services, and for Allison C Hanauer PhD LLC’s mental health care operations.

a. For Treatment. I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of Allison C Hanauer PhD LLC for your treatment by another health care provider, I will have you sign an Authorization for Release of Information.

b. For Payment. I may use and disclose your health information to obtain payment for services I provide to you as delineated in the “Agreement for Psychology Services” form. For example, I may need to give insurance companies or other agencies the minimum necessary information in order for them to pay us for the service I have provided to you.

c. For Health Care Operations. I may use and disclose your health information within Allison C Hanauer PhD LLC as part of my internal health care operations. For example, this could mean a review of records to assure quality by another licensed provider employed by the practice or administrative staff for administrative purposes. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

2. INFORMATION DISCLOSED WITHOUT YOUR CONSENT

Under Tennessee and federal law, information about you may be disclosed without your consent in the following circumstances.

a. Emergencies. Sufficient information may be shared to address an immediate emergency you are facing.

b. Judicial and Administrative Proceedings. I may disclose your personal health information in the course of a judicial or administrative proceeding in response to a valid court order or other lawful process, including if you were to make a claim for Workers Compensation.

c. Public Health Activities. If I felt you were an immediate danger to yourself or others, I may disclose health information about you to the authorities, as well as alert any other person who may be in danger.

d. Child/Elder Abuse. I may disclose health information about you related to the suspicion of child and/or elder abuse or neglect.

e. Criminal Activity or Danger to Others. I may disclose health information if a crime is committed on our premises or against our personnel, or if I believe there is someone who is in immediate danger.

f. National Security, Intelligence Activities, and Protective Services to the President and Others. I may release health information about you to authorized federal officials as authorized by law in order to protect the President or other national or international figures, or in cases of national security. This also allows limited to release of information to a military member’s commanding officer if necessary for purposes of national security.

g. Health Oversight Activities. I may disclose health information to a health oversight agency for activities authorized by law. These activities might include audits or inspections and are necessary for the government to monitor the health care system and assure compliance with civil rights laws. Regulatory and accrediting organizations may review your case record to ensure compliance with their requirements. The minimum necessary information will be provided in these instances.

h. Business Associates. Allison C Hanauer PhD LLC may disclose the minimum necessary health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, Allison C Hanauer PhD LLC uses the MyClients Plus electronic health record system and the associated Jitsu scheduling system. All of our business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
i. Research/Supervision. Under certain circumstances, Allison C Hanauer PhD LLC might use and disclose health information for research. Before I do so, any research project will go through a special approval process that includes a consent form for clients to sign if they are included in the research study/supervision.

j. Marketing. Allison C Hanauer PhD LLC may send you newsletters or information about services that you might be interested. You may at any time request that your name be removed from the mailing list. I will not disclose any information to a third party for their use in telemarketing, direct mail marketing, or marketing through electronic mail.

k. Scheduling Appointments. Allison C Hanauer PhD LLC may use your phone number to call/text you and leave messages to schedule or remind you of appointments.

3. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

a. Right to Inspect and Copy. You have the right to look at or get copies of your health information, with limited exceptions. Your request must be in writing. If you request a copy of the information, a reasonable charge may be made for the costs incurred. Health records are maintained for a minimum of seven years following termination of treatment or the date that a minor reaches legal majority.

b. Right to Amend. You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I have the right to deny your request under certain circumstances.

c. Right to an Accounting of Disclosures. You have the right to receive a list of instances in which I have disclosed your health information for a purpose other than treatment, payment, or health care operations. To request an accounting of disclosures, you must submit your request in writing. Such accountings are available for disclosures beginning April 14, 2003, and remain available for eight years after the last date of service at Allison C Hanauer PhD LLC.

d. Right to Request Restrictions. You have the right to request a restriction or limitation on the health information I use or disclose about you. For example, you could ask that I not share information with an insurance company, in which case you would be responsible to pay in full for the services provided. While you are in treatment, a written request should be made. To request a restriction after therapy is completed, you must make your written request. I am not required to agree to your request, but I will consider the request very seriously. If I agree, I will abide by our agreement unless the information is needed in an emergency or by law.

e. Right to Request Confidential Communications. You have the right to request that I communicate with you about health matters in a certain way or at a certain location. For example, you may ask that I contact you only by mail or at work. You must make this request in writing and it must specify the alternative means or location that you would like to use to provide you information about your health care. I will make every attempt to accommodate reasonable requests.

f. Right to Obtain a Paper Copy of this Notice. You have the right to receive a paper copy of this notice and any amended notice upon request. Copies will be available at the office of Allison C Hanauer PhD LLC. You may also obtain a copy of this notice at our web site, allisonhanauer.com. Any other uses and disclosures not set out in the information above will be made only with your written authorization. You may revoke a written authorization for release of information at any time. The revocation must be in writing and will become effective when it has been received by Allison C Hanauer PhD LLC and will only be for disclosures not already completed.

Allison C Hanauer PhD LLC reserves the right to change these privacy practices provided such changes are permitted by applicable law. Before the effective date of a material change, however, I will change this Notice and make a new Notice available to you at the reception desks or lobbies at each Center site and on our web site.

Beginning April 14, 2003, I am required to abide by the terms of Notice.

QUESTIONS AND COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with this office, or you may file a complaint with the U. S. Department of Health & Human Services www.hhs.gov/ocr/hipaa/. To obtain additional information, or to file a complaint with this office, contact me at (901) 302-6620. I will not retaliate in any way if you choose to file a complaint.

This Privacy Notice is effective 05/15/2014.