

Jonina D. Bolton, Ph.D.
Licensed Psychologist

Application for Clinical Services

Please Answer Each Question Completely

Today's Date: _____

Patient's Name: _____

Date of Birth: _____ Age: _____ Patient is (Please circle one): Male / Female / Other

Parent's Name (If patient is a minor): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: (_____) _____ Work: (_____) _____

Cell Phone: (_____) _____ E-mail Address: _____

Relationship Status (Please circle one): Single Engaged Married Partnered Widowed

Name of Significant Other and/or Emergency Contact: _____

Relationship to Patient: _____ Telephone: _____

Place of Employment or School: _____

Occupation/ Grade: _____

Primary Care Physician: _____ Telephone: _____

Current Medications and Doses: _____

Allergies or adverse Reactions to Drugs/Medications: _____

Please List Any Previous Therapists' Names: _____

How did you hear about Dr. Bolton? (Please Circle) Internet search / Dr. Bolton's website / Print Advertisement
Doctor Referral / Friend Referral

Referred By: _____

** May Dr. Bolton send a Thank You note to this person? (Please Circle One) Yes or No

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Please check any of the problems that apply to the Patient now, to the Patient in the past, or in the Patient's family.

<u>Now</u>	<u>Past</u>	<u>Family</u>	<u>Problem</u>
_____	_____	_____	Depression
_____	_____	_____	Anxiety/Worry
_____	_____	_____	Suicidal Thoughts/Attempts
_____	_____	_____	Loneliness
_____	_____	_____	Irritability/Anger
_____	_____	_____	Aggression/Violence
_____	_____	_____	Impulsivity
_____	_____	_____	Appetite/Eating Problems
_____	_____	_____	Self-Confidence
_____	_____	_____	Sleeping Problems/Nightmares
_____	_____	_____	Physical/Medical Problems
_____	_____	_____	Alcohol/Drugs/Gambling/Internet
_____	_____	_____	Physical Abuse
_____	_____	_____	Sexual Abuse
_____	_____	_____	Domestic Violence
_____	_____	_____	Grief/Loss
_____	_____	_____	Older Adult/Parent Problems
_____	_____	_____	Relationship/Divorce
_____	_____	_____	Child Problems
_____	_____	_____	Legal Problems
_____	_____	_____	School/Academic/Work Problems
_____	_____	_____	Psychiatric Hospitalizations

Other Problems of Concern or Important Information: _____

Patient Statement

I understand that I am voluntarily seeking psychological services and that I am giving my consent for Jonina D. Bolton, Ph.D. to provide services to me and/or my family member(s). **Name(s)** of person(s) receiving services:

Signature(s) of each person receiving services or parent/guardian of minor(s) and in agreement with the Patient Statement:

_____ **Date:** _____

_____ **Date:** _____

Dr. Jonina D. Bolton's Signature: _____ **Date:** _____

PAYMENT ARRANGEMENTS

Most individuals would like the benefit of working with their therapist for as long as is needed to accomplish their personal goals. The reality is that the manner in which you pay for your treatment may affect the extent of care that you receive. For example,

1. If you pay directly for your psychological services, then you and Dr. Bolton will determine the type of services that will benefit you the most and the length of time that you wish to remain in treatment.
2. If you chose to utilize your insurance benefits, then your insurance company may exercise a considerable amount of control over the services that you receive. Your insurance company will require Dr. Bolton to provide a diagnosis and description of treatment services that may determine the number of sessions that your insurance company will approve to cover. Many individuals are seeking therapy services to address issue or problems in their lives that do not meet criteria for a specific diagnosis. In these cases, insurance will not cover your services. Additionally, many companies require that the condition qualify for “medically necessary” treatment in order to be covered.
3. You can elect to pay directly for your treatment and then subsequently submit receipts yourself to your insurance company for reimbursement. However, your insurance company may require the same treatment information described above, limit the number of sessions for which they will reimburse you or deny reimbursement.
4. Insurance companies reserve the right to inspect client records for treatment review or quality assurance. Additionally, diagnoses and treatments related to your services are considered part of your medical record and may impact future insurance coverage or insurance rates impacted by pre-existing conditions.

As the result of the insurance issues described above, many people decide that the direct payment option, without any involvement of the insurance company, is best suited for their needs. The direct payment option allows for a higher degree of confidentiality while providing greater flexibility and autonomy in designing a treatment program most suited to your needs.

If you decide to use your insurance benefits, please be sure to contact your insurance company directly to determine whether an authorization number is required, prior to initiating treatment. Additionally, you may want to inquire about your specific coverage and to address any questions or concerns that you may have, such as:

1. Am I responsible for paying a deductible before my benefits apply?
2. What is my co-payment (flat fee) or co-insurance (percent of the fee) at the time of service?
3. How many sessions per year does my policy allow?

Payments Options:

1. Dr. Bolton currently accepts cash, checks and payment through online bill pay services through your bank. She does not accept credit cards or debit cards.
2. Payment is expected at the time that services are rendered.
3. You also have the option to pay for multiple sessions at a time, in advance, and the funds will be kept on your account. Fees will be deducted as services are utilized. You will be notified when payment will be due again.

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FINANCIAL AGREEMENT

Patient Name(s): _____ **Date of Birth:** _____

The patient, or responsible/accountable party (if the patient is a minor), is responsible for paying the fee at the time that services are rendered. If you plan to utilize insurance benefits, then please notify Dr. Bolton of your intention to do so, in advance. Dr. Bolton will submit insurance claims on your behalf to companies for which she is an in-network provider only. However, in the event that the claim(s) are denied by your insurance company, you will be held financially responsible for paying the fees in-full and for seeking reimbursement from your insurance company.

If the patient or responsible party has scheduled an appointment and chooses for any reason not to use that appointment time, then twenty-four (24) hour notice is required. If inadequate notice is given, or if a patient does not show for an appointment that he/she has reserved, then the patient or responsible party will be held financially responsible for paying the fee. The fee for the first two missed or cancelled appointments without 24-hour notice is **\$50.00**, with all subsequent missed or cancelled appointments being charged the full fee of **\$165.00** for the appointment. Insurance companies do not pay any portion of the fee for a missed or cancelled appointment and the reduced rate will not apply. ***I understand my financial responsibility for reserved appointments, including my responsibility to notify Dr. Bolton with at least 24-hour notice to avoid being charged a fee. Please initial here.*** _____

Fees are subject to annual increases. There is a charge of \$20.00 for all checks returned for insufficient funds. If your payment by check is returned on two occasions, then all subsequent payments must be made by other means.

The patient or responsible party is required to guarantee payment for services used. In the event that any collection procedures become necessary, the patient is responsible for all fees for services rendered, interest accrued, document preparation time, photocopying fees, and all costs of collection, including attorney fees and court fees.

Having been notified of these terms, I/we agree to the following fee arrangements:

Insurance pay: Deductible _____		
Co-pay of \$ _____ per therapy session		(initial here) _____
Co-insurance of % _____ per therapy session		(initial here) _____
Private pay fee of \$ _____ per therapy session		(initial here) _____
Private pay fee of \$ _____ per hour of testing		(initial here) _____
Private pay fee of \$ _____ other _____		(initial here) _____

Patient Signature(s): _____ **Date:** _____

_____ **Date:** _____

Jonina D. Bolton, Ph.D.: _____ **Date:** _____

For Insurance Pay Only:

Name of Primary Policy Holder: _____ Date of Birth: _____

Name of Primary Insurance Company: _____ Member ID# _____

Name of Secondary Insurance Company: _____ Member ID# _____

*Signature on File: I authorize the release of any clinical information necessary to process claims made on my behalf or that of my family member(s). Please accept a photocopy of this authorization as if it were an original. My signature below acts as the signature on file.

Signature: _____ **Date:** _____

*Assignment of Benefits: I hereby authorize and direct payment of insurance benefits to Jonina D. Bolton, Ph.D. for professional services rendered. I understand that I am financially responsible for all charges not covered by this assignment.

Signature: _____ **Date:** _____

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SERVICES AGREEMENT

WELCOME TO MY PRACTICE

This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and the patient, as well as the particular problems you are experiencing. There are many different methods I may use to approach the problems that you hope to address. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about, both during our 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. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems and significant reductions in feelings of distress. There are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, then we should discuss them whenever they arise. If your doubts persist, then I will be happy to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS

I normally conduct an evaluation that will last from 1 to 4 sessions. During this time, we can both decide if I am the best person to provide the services that you need in order to meet your treatment goals. If psychotherapy is begun, then I will usually schedule one appointment of 45-55 minutes duration per week, although some sessions may be longer or more frequent. **Once an appointment hour is scheduled, you will be charged a fee unless you provide 24 hours (1 day) advance notice of cancellation. You will also be charged for appointments that you do not show for. The first two (2) missed or cancelled appointments without adequate notice will be charged a fee of \$50.00, after which all subsequent missed or cancelled appointments will be charged the full fee of \$165.00.** It is important to note that insurance companies do not provide reimbursement for missed or cancelled sessions. If it is possible, then I will try to find another time to reschedule the appointment; however, you will still be expected to pay the fee for the missed appointment.

CONTACTING ME

Contacting me by telephone is the best option; however, I do not answer the telephone when I am with a patient. When I am unavailable, my telephone is answered by voicemail. I will make every effort to return your call in a timely manner. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychiatrist on call. If I will be out of the office for an extended period of time, then my voicemail message will indicate the expected date of my return. I will provide you with the name of a colleague to contact during my absence, on request. For matters that do not require a timely response, you may contact me by email.

PROFESSIONAL FEES

My hourly fee for therapy is \$165.00. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request. For testing or evaluation

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services, including report writing, my hourly fee is \$200.00. If you become involved in legal proceedings that require my participation, then you will be expected to pay for all of my professional time and costs, including preparation and transportation, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge \$300.00 per hour for preparation, travel and attendance at any legal proceeding. All professional fees are subject to yearly increases.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or you have insurance coverage that requires another arrangement. Payment for other professional services will be agreed to when they are requested. I charge a fee of \$20.00 for any returned check for insufficient funds. If this occurs on two occasions, then all future payments will have to be made by other means.

If your account has not been paid for more than 60 days and no arrangements for payment have been made with me, then I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, I release information regarding a patient's name, the nature of services provided and the amount due. If such legal action is necessary, then its costs will be included in the claim and you will be responsible for paying those fees in addition to the account balance.

DOCUMENT REQUESTS

Any request for documents, including creation or preparation of letters or copies of test reports, must be made at least 48 hours in advance. I require sufficient time to prepare appropriate documents and to research any necessary information pertinent to the situation. If I require additional time, then I will notify you at the time that your request is made. If your request involves the disclosure of clinical information directly to a third party, then an authorization form must be signed by the patient or responsible party before the document(s) can be released. My hourly fee may apply.

SOCIAL NETWORKING AND INTERNET SEARCHES

I do not accept requests to communicate on social networking sites from current or former patients, due to the fact that these sites can compromise patients' confidentiality and privacy. For the same reason, I request that you do not communicate with me via any interactive or social networking websites. At times, I may conduct a web search on individuals before or during treatment. If you have concerns or questions regarding this practice, then please discuss it with me.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may find it helpful to consult other health or mental health professionals. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Privacy Practices).
- I also have contracts with certain businesses and individuals. As required by HIPAA, I have a formal business associate contract with this/these business(es), in which it/they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, then you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

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- If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal information about a patient's treatment. These situations are unusual in my practice.

- If I know, or have reason to suspect, that a child under the age of 18 is abused, abandoned or neglected by a parent, legal custodian, caregiver or any other person responsible for the child's welfare, the law requires that I file a report with the Department of Child and Family Services. Once such a report is filed, I may be required to provide additional information.
- If I know or have reasonable cause to suspect, that a vulnerable adult has been, or is being, abused, neglected or exploited, the law requires that I file a report with the central abuse hotline. Once such a report is filed, I may be required to provide additional information.
- If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or seeking hospitalization of the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your Clinical Record. Except in unusual circumstances that disclosure would physically endanger you and/or others or makes reference to another person (other than a health care provider) and I believe that access is likely to cause harm to such other person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded directly to another mental health professional to discuss the contents. In most circumstances, I am allowed to charge a copying fee. The fee is \$2.00 for the first page and \$1.00 for each additional page, with a minimum charge of \$10.00 (and for other expenses). I may withhold copies of your records until payment of the copying fees has been made. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of PHI. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and my privacy policies and procedures. I am happy to discuss these rights with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. Children between 13 and 17 may independently consent to (and control access to the records of) diagnosis and treatment in a crisis situation. Because privacy in therapy is often crucial to progress, particularly with teenagers, and parental involvement is also essential, it is usually my policy to request an agreement with minors over 16

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years of age and their parents about access to information. This agreement provides that during treatment, I will provide parents only with general information about the progress of the treatment and the patient's attendance at sessions. I will also provide parents with a summary of their child's treatment when it is complete, if requested. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents. Before giving parents any information, I will discuss the matter with the patient, if possible, and do my best to handle any objections he/she may have.

E-MAILS, CELL PHONES, COMPUTERS AND E-FAXES

It is very important to be aware that computers and unencrypted email, texts and e-faxes communication (which are part of the clinical records) can be relatively easily accessed by unauthorized people and, hence, can compromise the privacy and confidentiality of such communication. Emails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access, due to the fact that servers or communication companies may have unlimited and direct access to all emails, texts and e-faxes that go through them. While I make every effort to secure data on my computer, emails, texts and e-faxes are not encrypted. It is always a possibility that e-faxes, texts, and emails can be sent erroneously to the wrong address or computer. Please notify me if you decide to avoid or limit, in any way, the use of email, texts, cell phones calls, phone messages or e-faxes. If you communicate confidential or private information via unencrypted email, texts, e-fax or via phone messages, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate on such matters. Please do not use texts, email, voicemail or faxes for emergencies.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have to pay for your treatment. If you have a health insurance policy, it may provide some coverage for mental health services. I will fill out forms and provide you with whatever help I can in assisting you to receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. You should carefully read the section in your insurance booklet that describes mental health services and coverage. If you have questions, then call your plan administrator. I will provide you with whatever information I can based on my experience and will be happy to help you understand the information you receive from your insurance company. If it is necessary for clarification, I will be willing to call the insurance company on your behalf.

It is sometimes difficult to determine how much mental health coverage is available. "Managed Health Care" plans, such as HMOs and PPOs, often require authorization before they provide reimbursement. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after their benefits end. Some managed-care plans will not allow me to continue to provide services to you. If this is the case, I will do my best to find another provider who will help you.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide. **I am required to provide a clinical diagnosis.** Sometimes, I am required to provide additional clinical information such as treatment plans, summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish within the benefit limits and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you have the right to pay for my services yourself to avoid the problems described above (unless prohibited by contract).

AUDIO OR VIDEO RECORDING

Unless otherwise agreed to be all parties beforehand, there shall be no audio or video recording of evaluations, therapy sessions, telephone calls or any other services provided by me.

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SERVICES AGREEMENT

Thank you for taking the time to review this Services Agreement and The Notice of Privacy Practices. I look forward to working with you.

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Your signature below indicates that you have read the information in the Services Agreement document, understand it, and agree to abide by its terms during our professional relationship. Your signature below also serves as an acknowledgment that you have received the HIPAA Notice of Privacy Practices described in this document.

Patient Name: _____

Patient Signature: _____

Date: _____

OR

Patient Name: _____

Name of Patient's Parent or Legal Representative: _____

Signature of Parent or Legal Representative: _____

Relation to the Patient: _____

Date: _____

I, a mental health professional, have discussed the issues above with the patient and/or his or her personal representative. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent to this Services Agreement.

Signature of Jonina D. Bolton, Ph.D.

Jonina D. Bolton, Ph.D.
Printed Name

Date

HIPAA NOTICE OF PRIVACY PRACTICES

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

Commitment to Your Privacy

Dr. Bolton is dedicated to maintaining the privacy of your personal health information as part of providing professional care. She is required by law to keep your information private. These laws are complicated, but she must give you this important information. Dr. Bolton will use information about your health, which she gets from you or from others, mainly to provide you with treatment, to arrange payment for services and for some other business activities which are called health care operations. After you have read this NPP, Dr. Bolton will ask you to sign a Consent Form that verifies that you have read this document and consent to allow her to use and share your information as outlined in this document. If you or Dr. Bolton wants to use or disclose (send, share, release) your information for any other purpose, then most situations will require your written permission and Dr. Bolton will ask you to sign an Authorization form.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Dr. Bolton may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- “*PHI*” refers to information in your health record that could identify you.
- “*Treatment, Payment and Health Care Operations*”
 - *Treatment* is when Dr. Bolton provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when Dr. Bolton consults with another health care provider, such as your family physician or another psychologist.
 - *Payment* is when Dr. Bolton obtains reimbursement for your healthcare. Examples of payment are when Dr. Bolton discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - *Health Care Operations* are activities that relate to the performance and operation of the practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “*Use*” applies only to activities within Dr. Bolton’s office, such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of Dr. Bolton’s office, such as releasing, transferring or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

Dr. Bolton may use or disclose PHI for purposes outside of treatment, payment and health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In instances when Dr. Bolton is asked for information for purposes outside of treatment, payment and health care operations, she will obtain a written authorization from you before releasing this information. Dr. Bolton will also need to obtain an authorization before releasing your psychotherapy notes. “*Psychotherapy notes*” are notes that Dr. Bolton has made about conversations during a private, group, joint or family counseling session, which has been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) Dr. Bolton has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy. Dr. Bolton will also obtain an authorization from you before using or disclosing PHI in a way that is not described in this Notice.

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III. Uses and Disclosures with Neither Consent nor Authorization

Dr. Bolton may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If Dr. Bolton knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that she report such knowledge or suspicion to the Florida Department of Child and Family Services.
- **Adult and Domestic Abuse:** If Dr. Bolton knows, or has reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected or exploited, she is required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.
- **Health Oversight:** If a complaint is filed against Dr. Bolton with the Florida Department of Health on behalf of the Board of Psychology, the Department has the authority to subpoena confidential mental health information from Dr. Bolton relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and Dr. Bolton will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform Dr. Bolton that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** When you present a clear and immediate probability of physical harm to yourself, to other individuals or to society, Dr. Bolton may communicate relevant information concerning this to the potential victim, appropriate family member, law enforcement or other appropriate authorities.
- **Worker's Compensation:** If you file a worker's compensation claim, Dr. Bolton must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.
- When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

There may be additional disclosures of PHI that Dr. Bolton is required or permitted by law to make without your consent or authorization; however, the disclosures listed above are the most common.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, Dr. Bolton is not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are receiving services from Dr. Bolton. On your written request, Dr. Bolton will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, Dr. Bolton will discuss with you the details of the request process.

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- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Dr. Bolton may deny your request. On your request, Dr. Bolton will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, Dr. Bolton will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from Dr. Bolton upon request, even if you have agreed to receive the notice electronically.
- *Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket*. You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for Dr. Bolton’s services.
- *Right to Be Notified if There is a Breach of Your Unsecured PHI*. You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) the risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Psychologist’s Duties:

- Dr. Bolton is required by law to maintain the privacy of PHI and to provide you with a notice of her legal duties and privacy practices with respect to PHI.
- Dr. Bolton reserves the right to change the privacy policies and practices described in this notice. However, unless Dr. Bolton notifies you of such changes, she is required to abide by the terms currently in effect.
- If Dr. Bolton revises her policies and procedures, then she will notify you in writing by mail or email, depending on the mode(s) of communication for which you have granted her permission to contact you.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision Dr. Bolton makes about access to your records, or have other concerns about your privacy rights, you may contact Dr. Jonina D. Bolton.

If you believe that your privacy rights have been violated and wish to file a complaint with Dr. Bolton’s office, you may send your written complaint to Dr. Jonina D. Bolton, 4731 Highway A1A, Vero Beach, Florida 32963.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Dr. Bolton can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. Dr. Bolton will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

Dr. Bolton reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that she maintains. Dr. Bolton will provide you with a revised notice by mail or email, depending on the mode(s) of communication for which you have granted her permission to contact you.

If you have any questions regarding this notice or the health information privacy policies, please contact the Privacy Officer for this office, Dr. Jonina D. Bolton. She can be reached by phone at 772-234-7100. The effective date of this notice is September 1, 2013.

Jonina D. Bolton, Ph.D.
Licensed Psychologist

Acknowledgment of Receipt of the Notice of Privacy Practices

I have received and read the Notice of Privacy Practices (NPP) for Dr. Bolton's office.

Name of Patient(s): _____

Signature of Patient(s): _____ Date: _____
_____ Date: _____

OR

Name of Parent/Guardian/Legal Representative (if the patient is a minor and/or legally represented by another person):

Signature of Parent/Guardian/Representative: _____ Date: _____

Refusal

It is your right to refuse to sign the document above. By signing below, you are acknowledging that refusal.

Name of Patient(s): _____

Signature of Patient(s): _____ Date: _____
_____ Date: _____

OR

Name of Parent/Guardian/Representative if patient is a minor or represented by another person:

Signature of Parent/Guardian/Representative: _____ Date: _____

Reason for Refusal

_____ I do not understand information included in the NPP and would like further explanation. (Please specify)

_____ I do not agree to the content of the NPP. (Please specify):

_____ Other: _____

_____ I do not wish to provide a reason for my refusal.

For Office Use Only:

The reason that a standard acknowledgment (such as above) of the receipt of the Notice of Privacy Practices was not obtained:

_____ Patient refused to sign. Witnessed by or communicated to: _____

_____ Communication barriers prohibited obtaining acknowledgement.

_____ An emergency situation prevented this office from obtaining it.

_____ Other: _____
