

**CONFIDENTIAL INTAKE FORM-ADULT**

**Identification**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Street, City, Zip) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Phone Number**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Voice message can be left on this number ○ Yes ○ No

Texts can be sent to this number ○ Yes ○ No

**Insurance Information**

Insurance Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Subscriber Information**

Name and Relationship to Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different from client)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

Name and Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Education

Highest Level of Education Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently a student? Yes No

If yes, Major: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Credit hours per semester: \_\_\_\_\_\_\_

# Employment

Current Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of years at this job: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Medical History

Please indicate any known complications while you were in utero (alcohol or drug use, maternal depression, medical conditions, domestic violence) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note any known issues or delays with meeting developmental milestones (delayed speech, walking etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current medical/health problems or pain issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current medication for physical problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past major medical/health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

# Substance Use History

Do you currently drink alcohol? Yes No

If yes, how often? 6-7 days week 3-5 days week 1-2 days week 2-3 times monthly

Less than monthly

Have you /do you ever use recreational drugs? Current Past Never

If yes, how often? 6-7 days week 3-5 days week 1-2 days week 2-3 times monthly

Less than monthly

Have you had any form of substance use treatment? None Outpatient Inpatient (Detox/Rehab)

# Legal History

Have you ever been arrested? Yes No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been on probation? Yes No

If yes, are you currently on probation? Yes No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental Health History**

Have you ever been in outpatient therapy? Yes No

If yes, approximate number of treatments: \_\_\_\_

Have you ever been in inpatient or day treatment? Yes No

If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been prescribed medication for mental health problems? Yes No

Current medication for mental health problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past medications for mental health problems:

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

Have you ever been hospitalized for mental health reasons? Yes No

If yes, how many times: \_\_\_\_\_\_\_\_\_\_\_\_

# Family History

Marital Status: Married Separated Divorced Widowed Never Married

Domestic Partnership

Describe your support systems (friends, family, groups, clubs): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list names of family members below. Please indicate if deceased.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Family Member | Quality of Relationship | Living With You | | |
| Mother |  |  |  | Yes No |
|  |
| Father |  |  |  | Yes No |
|  |
| Siblings (List All Below) |  |  |  | Yes No |
|  |
| Romantic Partner/Spouse |  |  |  | Yes No |
|  |
| Children (please include ages) |  |  |  | Yes No |
|  |

Have any of your relatives ever had a serious mental health problem? Yes No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have any of your relatives ever had a serious drug or alcohol problem? Yes No

If yes, please explain:

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

# Presenting Problem

Please describe what brought you in today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please rate the severity level of the issues or concerns you have been experiencing in the last month.

Please rate using a scale from 0 to 5.

0 represents NO issues or concerns and 5 represents highly significant issues or concerns.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Anger |  | Irritability |  | Mood swings |  |
| Anxiety/Worry |  | Panic Attacks |  | Racing Thoughts |  |
| Poor Concentration |  | Depressed Mood |  | Fidgety/Restlessness |  |
| Verbal Aggression |  | Physical Aggression |  | Control Issues |  |
| Easily Startled |  | Fatigue |  | Frequent Headaches |  |
| Freq. Stomachaches |  | Suicidal Thoughts |  | Desire to Self-Harm |  |
| Attempted Suicide |  | Frequent Nightmares |  | Flashbacks |  |
| Sleep Disturbance |  | Need to be on the Go |  | Lack of Motivation |  |
| Physical Abuse |  | Emotional Abuse |  | Specific Phobia(s) |  |
| Overeating |  | Undereating |  | Sig. Weight Changes |  |
| Hearing Voices |  | Visual Illusions |  | Self-Esteem Issues |  |
| Purging Food |  | Need for Routine |  | Need for Organization |  |
| Grief |  | Promiscuity |  | Feeling Hopeless |  |
| Over-Exercising |  | Paranoia |  | Codependency Issues |  |

**TRAUMA & LOSS HISTORY**

Please review the following list of events/experiences and check any that you have experienced.

|  |  |  |  |
| --- | --- | --- | --- |
| Check if Yes | Experience | Brief Detail (i.e. type of injury) | Your Age |
|  | Natural disaster or fire |  |  |
|  | Serious accident |  |  |
|  | Serious personal injury (physical assault/violence) |  |  |
|  | Serious illness |  |  |
|  | Death of a parent or other important parental figure |  |  |
|  | Serious injury or illness of a parent or other important guardian figure |  |  |
|  | Death of a sibling |  |  |
|  | Serious injury or illness of a sibling |  |  |
|  | Death of a friend |  |  |
|  | Serious injury or illness of a friend |  |  |
|  | Witnessing serious injury or death of another person |  |  |
|  | Prolonged or unexpected separation from your family of origin as a child |  |  |
|  | Separation/divorce of parents |  |  |
|  | Separation/divorce of a long-term personal relationship |  |  |
|  | Witnessing interpersonal violence (domestic violence, community violence, etc.) |  |  |
|  | Psychiatric illness in parent, caregiver, or close family member |  |  |
|  | Alcohol or drug abuse in parent, caregiver, or close family member |  |  |
|  | Physical abuse |  |  |
|  | Inappropriate exposure to sexual activities of others |  |  |
|  | Sexual abuse/rape |  |  |
|  | Active duty/combat of self or loved one |  |  |
|  | Other trauma or loss not listed |  |  |

Please sign below indicating that you have completed this intake form.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewer’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***CONSENT FOR TREATMENT***

CLIENT NAME:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF BIRTH: \_\_\_\_\_\_\_

By signing below I am giving consent for mental health treatment at The Women and Girls Empowerment Center (WAGE Center).  I understand that my consent for treatment can be revoked at any time, should I choose to discontinue services. With this is mind, it is understood that I am entering into a therapeutic relationship. As with any relationship, closure is important. A closing session is ideal when ending the therapeutic process. However, I do understand that if there is no contact or communication from me for a period of 60 days, it will be assumed that I no longer intend to remain active in the therapeutic relationship and my case will be closed.

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

Signature (Client/Parent)                                                                  Date

***AUTHORIZATION TO BILL HEALTH INSURANCE***

By signing below, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am authorizing WAGE Center to bill my insurance company named, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_for services rendered.  I understand by doing so, my health insurance will be given information regarding my mental health diagnosis and treatment, as deemed necessary for payment of services.  I understand that I am responsible for knowing information about my health insurance policy and providing such information to WAGE Center, for correct billing. I am also responsible to notify WAGE Center of any changes with my health insurance status.  I understand that ultimately I am responsible for all payment relating to any and all charges relating to treatment and services that I have received at WAGE Center and that billing insurance is not a guarantee of payment.

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

Signature (Client/Parent)                                                                  Date

***CONFIDENTIALITY***

Contents of all therapy sessions and acknowledgement that a client is receiving treatment services, are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client’s legal guardian. Noted exceptions are as follows:

As mandated by law, when a client discloses intentions or a plan to harm another person, The WAGE Center is required to warn the intended victim and report this information to legal authorities. If a client discloses or implies a plan for suicide, The WAGE Center is required to notify legal authorities and make reasonable attempts to notify the family or emergency contact listed, on behalf of the client.

If a client states or suggests that he or she is/has engaged in abuse of a child, The WAGE Center is required to report this information to Child Protective Services and/or legal authorities.  Child abuse includes any type of physical, emotional or sexual abuse, neglect or failure to protect a child.  This may also include admission of prenatal exposure to controlled substances that are potentially harmful.   If a minor client reports being the victim of past or present child abuse, the WAGE Center is required to report this information to Child Protective Services.  The WAGE Center will also notify parent or legal guardian, unless doing so will place the client in further danger.

By signing below I am acknowledging that I have reviewed confidentiality information for The WAGE Center.

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

Signature (Client/Parent)                                                                  Date

***CANCELLATION POLICY***

Please contact your therapist as soon as possible, if you are unable to keep a scheduled appointment.    Please understand that I am self-employed, and insurance does not pay for missed sessions. In order to pay expenses, I must require compensation for scheduled appointments that are missed, as I have reserved that time in your name. **With the exception of medical emergencies or inclement weather (for in person sessions), between 24 and 48 hours’ notice must be given, or you will be charged the full session fee for your scheduled appointment time.** If this occurs, the credit card on file will be automatically charged the full session amount.

If there are more than 2 late cancellations or missed appointments within a 6 month period, treatment will be terminated and you will be provided with referrals for another clinic or therapist, should you choose to continue treatment. Phone calls and text messages are generally answered within 24-48 hours.  If you are experiencing a life threatening emergency, please call 911 or go to the emergency room.  Do not await a return call to take necessary action to ensure client (you or your child’s) safety.

By signing below I am acknowledging that I have read and fully understand the cancellation policy at The Women and Girls Empowerment Center.  My signature also confirms my agreement that if I do not give **between** **24 to 48 hours’ notice**, with the exception of a medical emergency or inclement weather, the credit card on file will automatically be charged the full session fee. The full session fee is equivalent to the agreed upon cash rate or the insurance contracted rate for the scheduled appointment.

Credit Card Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exp Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVV Code \_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_

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

Signature (Client/Parent)                                                      Date

**NOTICE OF PRIVACY PRACTICES**

This notice describes how health information about you/your child may be used and disclosed and how you can get access to this information. Please review carefully, as the privacy of your personal health information (PHI) is important.

**CLIENT RIGHTS**

Although your/your child’s medical record is the physical property of the Women and Girls Empowerment Center, LLC (hereinafter referred to as WAGE Center), you have certain rights over your/your child’s PHI:

**Access:** You have the right to inspect and receive a copy of your/your child’s PHI. Your request must be in writing, and we may charge you a reasonable fee for copying your/your child’s information. If we use or maintain your/your child’s records electronically, you may get a copy of that information in electronic format and ask us to send it to a person or organization you identify. We will give you an electronic or written copy of your/your child’s records, usually within within 30 days of your request.

**Confidential Communications:** You have the right to receive confidential communications. You may request in writing to Wage Center that communications regarding your PHI be provided to you in a certain way or at a certain location. For example, you may prefer to receive mail regarding your PHI at an address other than your usual mailing address. You may specify how or where you wish to be contacted (via mail, email, text or phone calls).

**Right to Amend:** You have the right to ask us to amend your/your child’s PHI. If you believe your/your child’s PHI created or maintained by Wage Center is incorrect or incomplete, you may request an amendment to your/your child’s information. We may deny your request to amend information if the information was not created by us, maintained by us, or if we determine the information is accurate. You have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and provide you with a copy.

**Disclosure Accounting:** You have the right receive an accounting of certain disclosures made of your/your child’s PHI. You may request a listing of certain disclosures that we have made of your/your child’s PHI to entities or persons outside of our office.

**Restriction:** You have the right to request a restriction on the use or disclosure of your/your child’s PHI. You may request limitations on how we use or disclose your/your child’s PHI. For example, you may ask us not to use or disclose any part of your/your child’s PHI for the purpose of treatment, payment or healthcare operations. Such a request must be in writing. We will consider your request but, in most cases, are not legally obligated to agree to the restriction (e.g., if the use or disclosure is necessary in order to provide you/your child with emergency treatment or is otherwise required by law, your/your child’s PHI will not be restricted). However, we will comply with any request to restrict the disclosure of PHI to a health plan for purposes of payment or healthcare operations (not for treatment) if the PHI pertains solely to a healthcare item or service that has been paid for out-of-pocket and in full.

**Right to a Paper Copy of this Notice:** You have the right to receive a paper copy of this Notice upon request, even if you have signed this paper notice. You have the right to be notified of a breach. You have the right to be notified in the event that Wage Center (or one of our Business Associates) discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

* **Treatment**

We will use and disclose your/your child’s PHI to provide, coordinate or manage your/your child’s healthcare and any related services. This includes consultations, clinical supervisions or with other treatment team members. We may disclose your/your child’s health information to doctors or other providers that are providing treatment to you/your child. However, we will do so only with written authorization unless otherwise indicated in this notice.

* **Payment**

Your/your child’s PHI will be used, as needed, to obtain payment for your/your child’s health care services. For example, PHI is utilized to justify the level of care delivered to you/your child and the charges incurred for the services. This information generally accompanies the claim and is sent to your health plan or other third-party payers.

* **Healthcare Operations**

We may use or disclose your/your child’s PHI, as needed, in order to perform and support Wage Center routine health care operations. These operations include, but are not limited to, conducting quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, training health care and non-health care professionals, conducting legal and auditing services, conducting risk management activities and investigations, accreditation, certification, licensing, and credentialing activities. For training and teaching purposes PHI will be disclosed only after your authorization.

* **Appointments and Health-Related Management and Benefits**

We may use or disclose your/your child’s PHI, as necessary, to contact you to schedule an appointment or provide appointment reminders. We may also use or disclose your/your child’s PHI to manage or coordinate your healthcare. We may contact you by phone or other means to provide results from clinical assessments and to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you/your child.

* **Business Associates** We may enter into contracts with entities known as Business Associates that provide services to or perform functions on our behalf (such as a third party billing company). We may disclose PHI to Business Associates once they have agreed in writing to safeguard the PHI. Business Associates are also required by law to protect PHI.
* **Healthcare Information Organizations**

WAGE Center may elect to use a health information organization or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

* **Family and Friends** We may disclose your/your child’s PHI to a family member or friend who is involved in your care. If you do not want us to disclose your/your child’s medical information to family members or others involved in your/your child’s care, please inform your therapist. We may also use or disclose your/your child’s health information to notify (or assist in the notification of) a family member, legally authorized representative or other person responsible for your/your child’s care, of your/your child’s location and general condition. This may include disclosures of your/your child’s information to an organization assisting in disaster relief effort so that your family can be notified of your location and general condition.
* **Other Permitted Uses and Disclosures**

We are also permitted to use or disclose your PHI without your written authorization for the following purposes:

* If your/your child’s therapist believes that you/your child or someone else is in clear and imminent danger of harm, your/your child’s therapist is legally obligated to inform proper authorities and others in order to help prevent the harm from occurring.
* If you/your child provides information indicating that someone under 18-years-old is being abused, your/your child’s therapist is legally required to notify proper authorities.
* When there is reason to believe that a disabled person or an elderly person is being sexually or physically abused or is at risk of such abuse, the therapist is legally required to inform the proper authorities.
* In cases when a valid court order is issued for your/your child’s records, the therapist is bound by law to comply with such requests.
* If required we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations performing utilization and quality control.
* We may disclose your/your child’s PHI to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat.
* For purposes of research or marketing, PHI may only be disclosed with your written authorization.

**USES AND DISCLOSURES REQUIRING AUTHORIZATION**

Any uses and disclosures of PHI not described in this notice will be made only with your written authorization. You may revoke your authorization at any time provided the revocation is in writing, except to the extent that Wage Center has already taken action in reliance on your prior authorization.

**OUR RESPONSIBILITIES**

We are required by law to maintain the privacy of your PHI. We are required to give you this notice about our Privacy Practices, our legal duties and your rights concerning you/your child’s PHI. We must follow the Privacy Practices that are described in this notice while it is in effect. This notice takes effect upon entering into services with Wage Center and remains in effect until we replace or change it. We reserve the right to change our Privacy Practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. Before we make changes to our Privacy Practices, we will change this notice and the new notice will be available upon request or on our website at http://www.wagecenter.org.

**QUESTIONS AND COMPLAINTS**

If you have any questions or want more information about our Privacy Practices, you may ask your/your child’s therapist. If you are concerned that your privacy rights have been violated, you may file a complaint using the contact information listed at the end of this notice. You may also file a complaint to the U.S. Department of Health and Human Services for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-6966775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/). We will not retaliate against you for filing a complaint.

**Privacy Officer**: Melissa Persechini, LMSW, CAADC, CTP (734) 656-8225 or [melissa@wagecenter.org](mailto:melissa@wagecenter.org)

Women and Girls Empowerment Center, LLC 34935 Schoolcraft, Suite 208, Livonia, MI 48150

**ACKNOWLEDGMENT OF RECEIPT OF**

**NOTICE OF PRIVACY PRACTICES**

I understand that by signing this receipt of acknowledgment of Notice of Privacy Practices, I am acknowledging that I have received a copy of the Women and Girls Empowerment Center, LLC Notice of Privacy Practices.

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

Client’s Name

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

Please Print Your Name and Your Relationship to Client

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

Signature

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

Date

**For Office Use Only**

Written acknowledgment of receipt of Women and Girls Empowerment Center, LLC Notice of Privacy Practices could not be obtained for the following reason:

* Client/legal representative refused to sign
* Communication barriers prohibited obtaining of acknowledgment
* An emergency situation prevented obtaining acknowledgment
* Other (Please Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_