WRIGHT WELLNESS
www.wrightwellness.me
1398 W. Mayfield Rd., Suite 220
Arlington, TX 76015
office@wrightwellness.me
682.777.4325

PATIENT INFORMATION

Today's date: ______/______/_______

Identification

Legal Name:____ Age:______Date of Birth:____/____/_____

Preferred Name:__________________________________Sex (only required for insurance):______________

Gender Identity: _________________________________Preferred Pronouns:__________________________

Race & Ethnicity:____

Race & Ethnicity Details: ______________________________Preferred Language:_____________________

Home street address:____

City/State/Zip:____

Phone (Primary):__________________________________ Email: _____________________________________

Calls/texts/e-mails will be discreet, but please indicate any restrictions:_____________________________

Occupation /Employment status:____

Military Experience:________________________________Education:_________________________________

Relationship status: _____________________________Children: _____________________________________

Closest Relationships

Name____ Relationship___________________________

Name____ Relationship___________________________

Name____ Relationship___________________________

Emergency Contact

If an emergency arises and we cannot reach you directly and we need to reach someone close to you, whom should we call? By listing someone below, you give permission for them to be contacted in the case of an emergency:

#1 Name: ____

Phone: __________________________________ Relationship: _______________________________________

Address: ____

#2 Name: ____

Phone: __________________________________ Relationship: _______________________________________

Address: ____

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Primary Medical Care (A signed release is required for treatment coordination)

Primary Care Provider____

Location/Phone____

Legal History

Are you presently suing anyone or thinking of suing anyone? ❑ Yes ❑ No If yes, please explain:

____

Is your reason for coming to see us related to an accident or injury? ❑ Yes ❑ No If yes, please explain:

____

Are you required by a court, the police, or a probation/parole officer to have this appointment?

❑ Yes ❑ No If yes, please explain: ____

Have you every had to file a complaint or been involved in a lawsuit with another mental health professional? ❑ Yes ❑ No If yes, please explain:

____

Any other legal involvement or history? ____

____

For minors, has this minor been named in a custody agreement, court order, and/or divorce decree? ❑ Yes ❑ No If yes, please provide a copy of this document along with other standard paperwork and all applicable adults will be contacted in accordance with this agreement. Failure to provide this information initially will result in services being stopped until documentation is obtained.

Treatment and Symptom History

I. Mental Health Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before? ❑ No ❑ Yes If yes, please indicate:

What kind? ______________________________When?______________________

From whom? ____

For what? ____

With what results? ____

Reason for stopping treatment? ____

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II. Medication(s)

Do you have a **history** of taking medications for psychiatric or emotional problems?

❑ No ❑ Yes If yes, please indicate:

What medications and dosage? ____

____

____

Frequency?____

From whom? ____

For what? ____

With what results? ____

Reason for stopping treatment? ____

Do you ***currently*** take medications for psychiatric or emotional problems? ❑ No ❑ Yes If yes, please indicate:

What medications and dosage? ____

____

____

Frequency?____

From whom? ____

For what? ____

For how long? ____

With what results? ____

Any **drug allergies?**

❑ No ❑ Yes If yes, please describe what type of reaction you have experienced: ____________________

____

____

____

III. Other history

Do you have a history of abuse/neglect or any other kind of trauma, including complex trauma?

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❑ No ❑ Yes If yes, please describe what you are willing to:

____

____

____

IV. Are you currently concerned about abuse or dependency of a substance and/or a behavioral addiction? ❑ No ❑ Yes If yes, please provide details about your current use and/or behaviors including amount, frequency, and reasons for use/behavior:

____

____

____

V. Risk Assessment

Do you have a **history** of suicidal thoughts or attempted suicide in the past? ❑ No ❑ Yes If yes, please describe when and the circumstances: ____

____

____

Are you **currently** experiencing suicidal or homicidal thoughts? ❑ No ❑ Yes

Do you have a specific plan? ❑ No ❑ Yes If yes, please explain:

____

____

Do you have any family history of mental health conditions or past treatment? ❑ No ❑ Yes If yes, please describe what you are willing to: ____

____

____

Please check **all** MEDICAL conditions you **have had** or **are having**:

❑ AIDS/HIV Positive
❑ Alcoholism
❑ Anemia
❑ Anorexia
❑ Appendicitis
❑ Arthritis
❑ Asthma
❑ Bleeding Disorder
❑ Brain Injury
❑ Bronchitis
❑ Bulimia
❑ Cancer
❑ Cataracts
❑ Congestive Heart Failure
❑ Chicken Pox
❑ Dementia
❑ Diabetes
❑ Emphysema
❑ Epilepsy/Seizures
❑ Glaucoma
❑ Goiter
❑ Gout
❑ Heart disease
❑ Hepatitis
❑ Hernia

❑ Herpes
❑ High Blood Pressure
❑ High Cholesterol
❑ Kidney Disease
❑ Liver Disease
❑ Measles
❑ Meningitis
❑ Migraine Headaches
❑ Mononucleosis
❑ Multiple Sclerosis
❑ Mumps
❑ Pacemaker
❑ Parkinson's Disorder
❑ Pelvic Inflammatory
❑ Pneumonia
❑ Polio
❑ Prostate problems
❑ Rheumatic Fever
❑ Scoliosis
❑ Sexually Transmitted Disease
❑ Stroke
❑ Thyroid Problems
❑ Tuberculosis
❑ Ulcers
❑ UTIs
❑ Other: ____________
❑ Other: ____________
❑Other: ____________
❑ Other: ____________
❑ Other: ____________

Do you have a **history** of any prior surgeries? ❑ No ❑ Yes If yes, please indicate:

What years and for what reason and the outcome?____

____

____

Do you have any family history of major medical health conditions? ❑ No ❑ Yes If yes, please

describe what you are willing to: ____

____

Please check all **past** and **present** PSYCHIATRIC/PSYCHOLOGICAL diagnoses.

❑ ADHD/ADD
❑ Agoraphobia
❑ Alcohol Abuse or Dependence
❑ Anorexia
❑ Anxiety Disorder
❑ Bipolar Disorder
❑ Bulimia
❑ Depression
❑ Eating Disorder
❑ Generalized Anxiety
❑ Learning Disorder
❑ Intellectual Disability
❑ Obsessive Compulsive Disorder (OCD)
❑ Panic Disorder
❑ Personality Disorder
❑ Posttraumatic Stress Disorder
❑ Psychosis
❑ Schizophrenia
❑ Substance Abuse or Dependence
❑ Behavioral Addiction (gambling, etc)
❑ Other: ____________
❑ Other: ____________
❑ Other: ____________
❑ Other: ____________
❑ Other: ____________
❑ Other: ____________

Please check any **current symptoms or experiences** you have had within the last month and/or have prompted you to seek services.

❑ Excessive worry
❑ Excessive anxiety
❑ Very nervous

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❑ Muscle tension
❑ Sleep disturbance
❑ Pounding heart
❑ Accelerated heart rate
❑ Obsessive thoughts
❑ Compulsive behavior
❑ Phobias/Fears
❑ Rituals
❑ Depressed mood
❑ Irritable mood
❑ Fighting and arguing
❑ Watchful/aware
❑ Startle easily
❑ Elevated mood
❑ Euphoric mood
❑ Mood swings
❑ Decreased need for sleep
❑ Shortness of breath
❑ Nausea or upset stomach
❑ Fear of losing control
❑ More talkative than usual
❑ Racing thoughts
❑ Increase in activity
❑ Excessive spending
❑ Hearing voices
❑ Seeing visions or other people/objects
❑ Unusual beliefs
❑ Increased sadness
❑ Frequent crying
❑ Loss of interest or pleasure in activities
❑ Weight loss/gain
❑ Insomnia
or of "going crazy"
❑ Fear of dying
❑ Numbness or tingling in lips/fingertips
❑ Hypersomnia
❑ Trouble concentrating
❑ Increased indecision
❑ Drinking more
❑ Smoking more
❑ Eating more
❑ Eating less
❑ Change in sex drive or satisfaction
❑ Other: ______________
❑ Other: ______________
❑ Other: ______________
❑ Other: ______________
❑ Other: ______________

Chief Concern
How can we help? Please describe the main difficulty that has brought you to see us: ___________

____

____

____

____

Who Referred you?

Name: ____________________________________ Phone/Email: ______________________

May we have your permission to thank this person for the referral? ❑ Yes ❑ No

How did this person explain how we might be of help to you? ______________________________

Did you hear about us somewhere else? ❑ Internet ❑ Psychology Today ❑ Insurance

❑ Other____

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INFORMED CONSENT

Hello, and welcome to Wright Wellness! Psychotherapy and counseling is not an easy decision, and we are excited you are willing to take a step today towards a healthier you. This informed consent document contains important information about our professional services and business policies. Please read it carefully and let us know if you have any questions. We want you to have the best understanding you can of the services available at Wright Wellness.

PSYCHOTHERAPY AND COUNSELING SERVICES

Psychotherapy and counseling varies depending on the personalities of the therapist and patient, and the particular struggles you bring into session. There are many different methods we may use to deal with the struggles that you hope to address. Psychotherapy and counseling sessions are not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for your therapy to be most successful, we may recommend you work on things we talk about both during our sessions and at home.

RISKS AND BENEFITS

Psychotherapy and counseling can have benefits and risks. Since psychotherapy and counseling often involves discussing some unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. So, in other words, it may be more difficult initially before you begin to feel progress and relief. On the other hand, psychotherapy and counseling have been scientifically proven to have benefits for a wide variety of people and most issues or struggles. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

ABOUT OUR CLINICIANS

We see psychotherapy and counseling as collaborative, and we therefore want you to have thorough information about our professional training and related treatment approaches to better understand what kind of services we provide.

Our team is comprised of health professionals with a wide variety of areas of focus and expertise. For counseling services, our licensed clinicians include clinical psychologists and professional counselors. In addition to counseling, we also have yoga and health coaching services available, either as a separate service or in addition to your counseling experience.

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For more information about our staff and clinicians and the specific services they provide, please visit *www.wrightwellness.me*.

OUR WORK TOGETHER

Your first session will involve an evaluation of your symptoms, needs and goals of therapy. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and begin a treatment plan to follow, should you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with us. Psychotherapy and counseling involves a large commitment of time, money, and energy, so you should be very careful about the provider you select. If you have questions about our approaches, we should discuss them whenever they arise. If your doubts persist, we will be happy to provide a list of other providers. We value your input, and want us to collaborate and work together towards your goals.

To be clear, psychologists and counselors can never have any other role in your life. We cannot, now or ever, be a friend, or socialize with any of our patients. We cannot be a therapist to someone who is already a friend or family member, and we can never have a sexual, romantic, or business relationship with any of our patients during, or after, the course of treatment.

CANCELLATION POLICY

We generally schedule one 50 to 55-minute session at a frequency we agree on, although we will decide on the frequency of treatment after the initial evaluation. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation** [unless we both agree that you were unable to attend due to circumstances beyond your control]. If it is possible, we will work with you to find another time to reschedule the appointment. We understand that unplanned circumstances can prevent you from making your session, however we ask that you communicate with us in a timely manner so that we can offer that appointment slot to someone else in need.

CONTACTING US

We are often not immediately available by telephone, and not always in the office. We do our best to return our own calls, but will not answer the phone when we are with a patient. If we are unavailable, you also have the option to leave a voice mail for our office manager or send us an email. We will make every effort to return your message

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as soon as possible, usually within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform us of times when you will be available.

If you are unable to reach us and it is an emergency or crisis, call 911 or go to the nearest emergency room to receive immediate care. If there is an emergency, and we become concerned about yours or someone else's safety, we may need to call your emergency contact, or a close relative or friend.

If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact as requested.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist or counselor is protected by law, and we can only release information about our work to others with your written permission. **However, there are a few exceptions:**

There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a patient's treatment. For example, if we believe that a child, elderly person, or disabled person is being abused or neglected, we must file a report with the appropriate state agency.

If we believe that a patient is threatening serious bodily harm to another, we may feel compelled to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If the patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations rarely occur. If a similar situation occurs, we will make every effort to fully discuss it with you before taking any action.

In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order our testimony if he/she determines that the issues demand it.

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We may occasionally find it helpful to consult other professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patients. The consultant is also legally bound to keep the information confidential. If you do not object, we will not tell you about these consultations unless we feel that it is important to our work together.

Also, we do occasionally run into patients outside of the office. If this occurs, we will take your lead. If you say hello, we will as well, but will wait for you to approach us, and will do our best to make the interaction brief and to maintain your confidentiality to the best of our ability.

It is also important to note the limitations of confidentiality when communicating through email. Although we are open to communication through email for specific reasons and will do our best to maintain your confidentiality, there is always a risk due to viruses, hackers, etc. Therefore, if you choose to communicate with us through email or text, you accept and assume all associated risks.

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 at our next meeting. We will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are complex, and we are not an attorney.

PROFESSIONAL FEES

Payment for services is an important part of our professional work together. We provide professional services on a fee-for-service basis. All of our clinicians accept private pay, as well as are in network with several insurance companies. For those we are in network with, we can bill claims for your counseling sessions. When using insurance, please note you are responsible for your associated co-pays, deductibles, or any amounts your insurance does not pay. We do our best to confirm coverage ahead of time, but payment by insurance is never guaranteed until the claim is processed.

Our clinicians are in network with various insurance companies, and are not all in network with the same insurance plans. Please contact us directly or visit *www.wrightwellness.me* for the most current list of insurance plans accepted by each clinician. If your clinician does not accept your particular insurance, you have the option to pay him/her directly and he/she can provide a "super-bill" for you to submit

to your insurance company for possible out of network reimbursement.

In addition to counseling appointments, each clinician will charge an hourly rate for other professional services you may need, including paperwork such as letters and other documents, though she will break down the hourly cost if she works for periods of less than one hour. Other services might include report writing, telephone conversations, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other professional service requested of her, including court subpoenas. Please note that we cannot bill insurance companies for these services.

Additional services available include yoga services, health coaching, and telehealth options for counseling sessions. Please contact us directly or visit our website for more information about these additional services.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, we may be willing to negotiate a fee adjustment or payment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. We prefer to avoid this option and ask our patients to work with us to settle any balances.

We accept cash, check, or credit card. We do request that you keep a credit card on

file with us for billing purposes, which are further outlined in the Agreement for Credit Card Authorization form.

INSURANCE REIMBURSEMENT

Please note that our clinicians are in network with various insurance companies.

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Please contact us directly or visit *www.wrightwellness.me* for the most current list of insurance plans accepted by each clinician.

For insurance companies that we are considered an out-of-network provider, we can provide you with a "super-bill" statement that details the services provided so that you can submit the information to your insurance for possible out-of-network reimbursement.

It is important to note that paying for psychotherapy or counseling services without insurance benefits gives both your therapist and you more control of your treatment. However, we also understand the out of pocket expense for treatment, and therefore we accept the health insurance plans indicated above.

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We can fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services.

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 a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow us to provide services to you once your benefits end. If this is the case, we will

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do our best to find another provider who will help you continue your psychotherapy or agree on a private payment plan.

You should also be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). 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, we 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. We will provide you with a copy of any report we submit, if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above, which is one common benefit to not using insurance benefits for psychotherapy or counseling.

PROFESSIONAL RECORDS

The laws and standards of mental health treatment require that we keep treatment records. You may request in writing a copy of your records, or we 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, we recommend that you review them in our presence so that we can discuss the contents. Patients will be charged an appropriate fee as outlined above for any professional time spent in responding to information requests.

MINORS

If you are under eighteen years of age, please be aware that the law gives your parents the right to examine your treatment records. We may request an agreement from parents that they agree to give up access to your records. If they agree, we may provide them only with general information about our work together, unless we feel there is a risk that you will seriously harm yourself or someone else. In this case, we will notify them of our concern. We may also provide them with a summary of your treatment. Before giving any information, we will do our best to discuss the matter with you, if possible, and do our best to handle any concerns you may have.

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DISCHARGE/TERMINATION

Please remember if you miss a scheduled appointment and do not call the office to reschedule within 30 days, we will take that as your notice that you have decided to terminate treatment with us. In the event of your therapist's death or disability, you authorize Wright Wellness to take appropriate steps to find a suitable custodian of your records.

COMPLAINT PROCEDURES

Please let us know immediately if you have any questions, concerns or complaints first, as we will always strive to problem solve and work with you to the best of our ability. However, if we are not able to solve the issue, and/or you feel that you have ever been treated unfairly by any of our clinicians or another mental health professional , you can also contact the state licensing board. Anyone who wishes to file a complaint against a healthcare professional in this state may call the Health Professions Council toll-free complaint referral system: 1-800-821-3205. This automated, statewide number routes a complainant to the appropriate licensing agency. The Texas Behavioral Health Executive Council investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers and licensed specialists in school psychology. Although not every complaint against or dispute with a licensee involves professional misconduct, the Executive Council will provide you with information about how to file a complaint. Please call 18008213205 for more information; address: 333 Guadalupe St, Tower 3, Room 900 | Austin, Texas 78701; https://www.bhec.texas.gov/index.html.

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INFORMED CONSENT SIGNATURE PAGE

I acknowledge that I have received, have read (or have had read to me), and understand the information about the psychotherapy or counseling I am considering. I have had all my questions answered fully, and agree to abide by the terms outlined above.

I do hereby seek and consent to take part in the treatment by the psychologist or counselor I have chosen to work with. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to us as to the results of treatment or of any procedures provided by the psychologist or counselor.

I am aware that I may stop my treatment with this psychologist or counselor at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment.

I know that I must call to cancel an appointment at least 48 hours before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that if I use insurance, an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive.

I understand that if payment for the services I receive at Wright Wellness is not made, the psychologist or counselor may stop my treatment.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Name of Patient:____

Signature of Patient:_____________________________ Date:____________

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
Privacy is a very important concern for all those who come to this office. It is also complicated, because of the many federal and state laws and our professional ethics. Because the rules are so complicated, some parts of this notice are very detailed, and you probably will have to read them several times to understand them. If you have any questions, we will be happy to help you understand our procedures and your rights.

Contents of this notice

1. Introduction: To our patients
2. What we mean by your medical information
3. Privacy and the laws about privacy
4. How your protected health information can be used and shared
    1. Uses and disclosures with your consent
       a. The basic uses and disclosures: For treatment, payment, and health care operations b. Other uses and disclosures in health care
    2. Uses and disclosures that *require* your authorization
    3. Uses and disclosures that *don't require* your consent or authorization
       a. When required by law
       b. For law enforcement purposes
       c. For public health activities
       d. Relating to decedents
       e. For specific government functions
       f. To prevent a serious threat to health or safety
    4. Uses and disclosures where you have *an opportunity to object*
    5. An *accounting* of disclosures we have made
5. Your rights concerning your health information
6. If you have questions or problems

Introduction: To our patients

This notice will tell you how we handle your medical information. It tells how we use this information here in this office, how we share it with other professionals and organizations, and how you can see it. We want you to know all of this so that you can make the best decisions for yourself and your family. If you have any questions or want to know more about anything in this notice, please ask us for more explanations or more details.

What we mean by your medical information

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Each time you visit us or any doctor's office, hospital, clinic, or other health care provider, information is collected about you and your physical and mental health. It may be information about your past, present, or future health or conditions, or the tests and treatment you got from me or from others, or about payment for health care. The information we collect from you is called **"PHI,"** which stands for "protected health information." This information goes into your medical or health care records in our office.

In this office, your PHI is likely to include these kinds of information:

- Your history: Things that happened to you as a child; your school and work experiences; your marriage and other personal history.
- Reasons you came for treatment: Your problems, complaints, symptoms, or needs.
- Diagnoses: These are the medical terms for your problems or symptoms.
- A treatment plan: This is a list of the treatments and other services that we think will best help you.
- Progress notes: Each time you come in, we write down some things about how you are doing, what we notice about you, and what you tell us.
- Records we get from others who treated you or evaluated you.
- Psychological test scores, school records, and other reports.
- Information about medications you took or are taking.
- Legal matters.
- Billing and insurance information
- There may also be other kinds of information that go into your health care records here.

We use PHI for many purposes. For example, we may use it:

- To plan your care and treatment.
- To decide how well our treatments are working for you.
- When we talk with other health care professionals who are also treating you, such as your family doctor or the professional who referred you to us.
- To show that you actually received services from us, which we billed to you or to your health insurance company.
- For teaching and training other health care professionals.
- For medical or psychological research.
- For public health officials trying to improve health care in this area of the country.
- To improve the way we do our job by measuring the results of our work.

When you understand what is in your record and what it is used for, you can make better decisions about who, when, and why others should have this information.

Although we are the custodian of your health care records in our office, the information belongs to you. You can read your records, and if you want a copy, we can make one for you (but we will charge you for the costs of copying and mailing, if you want it mailed to you). In

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some very rare situations, you cannot see all of what is in your records. If you find anything in your records that you think is incorrect or believe that something important is missing, you can ask us to amend (add information to) your records, although in some rare situations we don't have to agree to do that. We can explain more about this if requested.

Privacy and the laws about privacy

We are required to tell you about privacy because of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requires us to keep your PHI private and to give you this notice about our legal duties and privacy practices. We will obey the rules described in this notice. If we change our privacy practices, they will apply to all the PHI we keep. We will also post the new notice of privacy practices in our office where everyone can see. You or anyone else can also get a copy from our office at any time. It is also posted on our website at www.wrightwellness.me.

How your protected health information can be used and shared

Except in some special circumstances, when we use your PHI in this office or disclose it to others, we share only the minimum necessary PHI needed for those other people to do their jobs. The law gives you rights to know about your PHI, to know how it is used, and to have a say in how it is shared. So we will tell you more about what we do with your information.

Mainly, we will use and disclose your PHI for routine purposes to provide for your care, and we will explain more about these below. For other uses, we must tell you about them and ask you to sign a written authorization form. However, the law also says that there are some uses and disclosures that don't need your consent or authorization.

Uses and disclosures with your consent

After you have read this notice, you will be asked to sign a separate consent form to allow me to use and share your PHI. If we intend to use your PHI here or share it with other people or organizations to provide treatment to you, arrange for payment for our services, or some other business functions called "health care operations," we will need your consent. In other words, we need information about you and your condition to provide care to you. You have to agree to let us collect the information, use it, and share it to care for you properly.

The basic uses and disclosures: For treatment, payment, and health care operations

For treatment. We use your medical information to provide you with psychological treatments or services. These might include individual, family, or group therapy; psychological, educational, or vocational testing; treatment planning; or measuring the benefits of our services. We may share your PHI with others who provide treatment to you. We may share your information with your personal physician. If you are being treated by a team, we can share some of your PHI with the team members, so that the services you receive will work best together. The other professionals treating you will also enter their findings, the actions they took, and their plans into your medical record, and so we can decide what

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treatments work best for you and make up a treatment plan. We may refer you to other professionals or consultants for services we cannot provide. When we do this, we need to tell them things about you and your conditions. We will get back their findings and opinions, and those will go into your records here. If you receive treatment in the future from other professionals, we can also share your PHI with them. These are some examples so that you can see how we use and disclose your PHI for treatment.

For payment. We may use your information to bill you, your insurance, or others, so we can be paid for the treatments we provide to you. We may contact your insurance company to find out exactly what your insurance covers. We may have to tell them about your diagnoses, what treatments you have received, and the changes we expect in your conditions. We will need to tell them about when we met, your progress, and other similar things.

For health care operations. Using or disclosing your PHI for health care operations goes beyond our care and your payment. For example, we may use your PHI to see where we can make improvements in the care and services we provide. We may be required to supply some information to some government health agencies, so they can study disorders and treatment and make plans for services that are needed. If we do, your name and personal information will be removed from what we send.

Other uses and disclosures in health care

Appointment reminders. We may use and disclose your PHI to reschedule or remind you of appointments for treatment or other care. If you want us to call or write to you only at your home or your work, or you prefer some other way to reach you, we usually can arrange that. Just tell us.

Treatment alternatives. We may use and disclose your PHI to tell you about or recommend possible treatments or alternatives that may be of help to you.

Other benefits and services. We may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Research. We may use or share your PHI to do research to improve treatments—for example, comparing two treatments for the same disorder, to see which works better or faster or costs less. In all cases, your name, address, and other personal information will be removed from the information given to researchers. If they need to know who you are, we will discuss the research project with you, and we will not send any information unless you sign a special authorization form.

Business associates. We may hire other businesses to do some jobs for us. In the law, they are called our "business associates." Examples include a copy service to make copies of your health records, and a billing service to figure out, print, and mail our bills. These business associates need to receive some of your PHI to do their jobs properly. To protect your privacy, they have agreed in their contract with me to safeguard your information.

Uses and disclosures that require your authorization

If we want to use your information for any purpose besides those described above, we need your permission on an authorization form. We don't expect to need this very often. If you do allow us to use or disclose your PHI, you can cancel that permission in writing at any time. We would then stop using or disclosing your information for that purpose. Of course, we cannot take back any information we have already disclosed or used with your permission.

Uses and disclosures that don't require your consent or authorization

The law lets us use and disclose some of your PHI without your consent or authorization in some cases. Here are some examples of when we might do this.

When required by law. There are some federal, state, or local laws that require us to disclose PHI:

- We have to report suspected child abuse. If you are involved in a lawsuit or legal proceeding, and we receive a subpoena, discovery request, or other lawful process, we may have to release some of your PHI. We will only do so after trying to tell you about the request, consulting your lawyer, or trying to get a court order to protect the information they requested. We have to disclose some information to the government agencies that check on me to see that we are obeying the privacy laws.

For law enforcement purposes. We may release medical information if asked to do so by a law enforcement official to investigate a crime or criminal.

For public health activities. We may disclose some of your PHI to agencies that investigate diseases or injuries.

Relating to decedents. We may disclose PHI to coroners, medical examiners, or funeral directors, and to organizations relating to organ, eye, or tissue donations or transplants.

For specific government functions. We may disclose PHI of military personnel and veterans to government benefit programs relating to eligibility and enrollment. We may disclose your PHI to workers' compensation and disability programs, to correctional facilities if you are an inmate, or to other government agencies for national security reasons.

To prevent a serious threat to health or safety. If we come to believe that there is a serious threat to your health or safety, or that of another person or the public, we can disclose some of your PHI. We will only do this to persons who can prevent the danger.

Uses and disclosures where you have an opportunity to object

We can share some information about you with your family or close others. We will only share information with those involved in your care and anyone else you choose, such as close friends or clergy. We will ask you which persons you want me to tell, and what information you want me to tell them, about your condition or treatment. You can tell me what you want, and we will honor your wishes as long as it is not against the law.

If it is an emergency, and so we cannot ask if you disagree, we can share information if we believe that it is what you would have wanted and if we believe it will help you if we do share it. If we do share information, in an emergency, we will tell you as soon as we can. If you don't approve we will stop, as long as it is not against the law.

An accounting of disclosures we have made. When we disclose your PHI, we must keep some records of whom we sent it to, when we sent it, and what we sent. You can get an accounting (a list) of many of these disclosures.

Your rights concerning your health information

- You can ask us to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
- You have the right to ask us to limit what we tell people involved in your care or with payment for your care, such as family members and friends. We don't have to agree to your request, but if we do agree, we will honor it except when it is against the law, or in an emergency, or when the information is necessary to treat you.
- You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you.
- If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our office address. You must also tell us the reasons you want to make the changes.
- You have the right to a copy of this notice. If we change this notice, we will post the new one in our waiting area, and you can always get a copy from us.
- You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with us and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.
- You may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

If you have questions or problems

If you need more information or have questions about the privacy practices described above, please contact us directly at the above office number. If you have a problem with how your PHI has been handled, or if you believe your privacy rights have been violated, contact us. As stated above, you have the right to file a complaint with us and with the Secretary of the U.S. Department of Health and Human Services. We promise that we will not in any way limit your care here or take any actions against you if you complain. If you have any questions or problems about this notice or our health information privacy policies, please contact us directly at the above office number.

Effective date of notice 09/08/2014

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Notice of Privacy Practices Signature Page

Your signature below acknowledges that you have read our notice of privacy practices (NPP), which explains in more detail what your rights are and how we can use and share your information:

______________________________________ Printed Name

______________________________________ Signature of Individual Acknowledging NPP

______________________ Date

You may keep a copy of the NPP. Please return this signature page to Wright Wellness, PLLC for record keeping.

❑ Patient does not agree to the privacy practices explained above.

______________________________________ Wright Wellness, LLC provider

________________________ Date

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Agreement to Pay for Professional Services

I request that Wright Wellness, PLLC, provide professional services to me or my family member, and I agree to pay the fees (outlined in the Informed Consent handout) for these services at the end of each session or otherwise discussed. I agree that this financial relationship with this provider will continue as long as the provider provides services or until I or my family member inform them that I wish to end it. I or my family member agree to make every effort to discuss my concerns with this provider at least once before stopping services. I agree to pay for services provided to me or my family member up until the time the professional relationship has ended.

I understand that balances such as copays, deductibles, insurance co-share amounts, or appointment charges are invoiced the business day after appointments, then automatically processed to my default payment method overnight. This feature is called *AutoPay* and may be paused if I need to schedule payment for a later date or use a different payment method. If I would like to *pause or opt out of AutoPay* to make a different payment arrangement, I understand that I need to contact Wright Wellness immediately. If I opt out of AutoPay, I agree to make a payment after each session unless otherwise discussed with my provider. I understand that I must still add a credit card to be kept on file securely, even though I am choosing to opt-out of AutoPay. I understand that I may be automatically enrolled in AutoPay if I miss payments until I request to opt-out again or make other payment arrangements, or my services with Wright Wellness may be paused.

I also agree to pay for and authorize Wright Wellness to charge my credit/debit card in full for any late notice/no show fees or any balance that is 30 days overdue on my account (including co-payments, deductibles, other professional services or any amount not covered by my insurance) unless another arrangement has been discussed. I understand that services might be paused until payment is made. If I schedule payments, I understand the amount agreed upon will be processed on or after the date requested. I understand the importance of communication with Wright Wellness regarding my payments, and that I can contact Wright Wellness with any general questions about billing, payment plans, or requesting to opt out of AutoPay by calling or texting our billing manager at *682.226.6327* or emailing *billing@wrightwellness.me*.

I agree by providing my signature below that I am responsible for the charges for services provided by this provider to me or my family member, although other persons or insurance companies may make payments for these services as well.

Name on credit/debit card:____

Billing Address :____

Credit Card Number:__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ CCV: __ __ __ __

Exp. Date __ __ / __ __ Card Holder's Signature:____

____ ________________________

Signature of Patient Date