FAMILY STRATEGIES
COUNSELING CENTER

1745 S Alma School Rd., Suite 230, Mesa, AZ 85210 Phone: 480-668-8301 FAX 480-558-3020
(Just South of the 60. Southeast corner of Alma School and Isabella)

NEW CLIENT INFORMATION ***(Please Print Clearly)*** ***Revised 2/19/20***

CLIENT NAME: ______________________________ ______________ ________
First **Last** Date of Birth: (MM/DD/YYYY) Age

Parent(s) Name (for minor child only):______________________________
NOTE: If parents are divorced, court custody documents must be provided prior to the first session.
If parents share joint custody, both must sign the "Client Consent" form.
Current school *(if applicable)*: ______________________________ Grade: _______

ADDRESS: ______________________________
City State Zip

Gender: ____Male ____Female Employer: __________________ Occupation: __________________

CURRENT STATUS: Married: _____ Single: _____ Divorced: _____ Separated: _____ Widow/Widower: _____

Who do you authorize Family Strategies to speak with about your schedule appointments?

Who do you authorize Family Strategies to speak with about your account financial matters? __________________

Their relationship to you: __________________ **Your signature** ______________________________

Text/Cell number: __________________ Home Phone: __________________
If someone needs to call you, please indicate which number to use: ______ Cell ______ Home _____ Either

Email Address: ______________________________
You will receive periodic emails about our services and specialty programs. If you do not wish to receive these, please use the "unsubscribe" link in those periodic emails. We DO NOT sell or provide emails to others

What would you prefer your username be for our Patient Portal? ______________________________

EMERGENCY CONTACT

Name: ______________________________
First Last Phone

EXCHANGE OF CONFIDENTIAL INFORMATION

In efforts to provide me with the best possible care, I hereby authorize my therapist to exchange confidential information regarding my treatment to ***other professional staff at Family Strategies***. Professional staff includes, but are not limited to, the Clinical Director, Clinical Supervisors, and other therapists who have expertise regarding specific clinical issues and treatment planning. I give this authorization of my own free will and have discussed any questions or concerns with my therapist. By signing this consent to exchange confidential information, I acknowledge that I have both read, understood and that I agree to all the terms of this release. I understand that my records are protected under Federal and State Confidentiality Regulations.

______________________________ Date __________________
Signature of Client or Legal Guardian if client is under the age of 18

HOW DID YOU HEAR ABOUT FAMIILY STRATEGIES? ________________________________

THERAPIST YOU ARE SCHEDULED TO SEE: __________________________________

WERE YOU REFERRED? ____ Yes ____ No

IF YES, WHOM MAY WE THANK? ____

FINANCIAL RESPONSIBILITY

Name: ____ ____________ ________________
Last First Relationship Date of Birth

Address: ____
City State Zip

Phone: ____
Home Work Mobile

Email Address: _____________________________________

I accept full responsibility for all fees due to professional services. I realize that any third party billing is out of courtesy to me and does not transfer any financial responsibilities for unpaid services.

If I have Blue Cross Blue Shield Insurance, I understand that I am responsible for any allowable amount that BCBS does not cover.

If you as client are an adult and a family member or friend is providing payment in your behalf, do you authorize Family Strategies to speak with them regarding the financial aspect of your account?

______Yes ______ No

*Signature of Responsible Party (**Required**):* _________________________ Date: ________________

BCBS INSURANCE CLIENTS ONLY. **All Information is Required.**

PRIMARY INSURED : ________________________________ RELATIONSHIP TO CLIENT: ________________

PRIMARY INSURED DATE OF BIRTH: __________ Gender: ____Male ____Female SSN:

PRIMARY INSURED ADDRESS____
Street City State Zip

PRIMARY INSURED EMPLOYER: ________________________________

GROUP #: __________________________ SUBSCRIBER #: _________________________________

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD AT FIRST APPPOINTMENT.

PLEASE STATE THE REASON YOU ARE SEEKING COUNSELING

____

____

BEHAVIORAL HEALTH HISTORY:

Do you have a history of depression? _______ Yes _________ No
Have you ever taken medication for depression? _______ Yes _________ No

Does any member of your family have a history of depression? _______ Yes _________ No
Does any member of your family have a history of mental illness? _______ Yes _________ No

Have you **previously** received help through counseling? _______ Yes _________ No
If yes, who was your therapist? ____
Are you **currently** working with another therapist? _______ Yes _________ No
If yes, what is this therapist's name? ____
Do you authorize Family Strategies to communicate with this therapist? _______ Yes _________ No. I do NOT authorize

Your signature: ____

OVERVIEW OF MEDICAL HISTORY:

Do you have a Primary Care Physician? _______ Yes _________ No
PCP Name: ____ Phone: ____________________________
What is the date of your last physical exam? ____________________________________
Do you authorize Family Strategies to communicate with your PCP? _______ Yes _________ No. I do NOT authorize

Your signature: ____

Please list any hospitalizations in the last year: ____

Please check (☐) if you currently have, or have had, any symptoms or problems in any of the following areas to a significant degree:

☐ Chest/heart ☐ Head/Brain Injury ☐ Neck ☐ Intestinal ☐ Kidneys
☐ Lungs/Respiratory ☐ Ear/Nose/Throat ☐ Back ☐ Skin ☐ Reproductive
☐ Bladder ☐ Bowel ☐ Other: ____

Please, briefly describe your symptoms:

Have you had, or do you currently have, any medical conditions or diseases? Please list: ______________________________

____

Please list the medical conditions your parents, grandparents or siblings have had or currently have and indicate which family member:

Please list any medications you currently take **and** the condition for which you take them:
Medication: _______________________________________ Taken for: ______________________________
Medication: _______________________________________ Taken for: ______________________________
Medication: _______________________________________ Taken for: ______________________________
Medication: _______________________________________ Taken for: ______________________________
Medication: _______________________________________ Taken for: ______________________________

Please list any medications you are allergic to: ____

Do you currently have an infectious disease? _________ Yes _________ No

This is a self-report – Please note any that apply:
____ Strep ____ Lice ____ HIV ____ STD ____ Chicken Pox ____Measles, Mumps, Rubella ____ Bed Bugs
____ Other: (Please list) ____

Do you have a learning disability?
____ ADHD ____ APD ____Dyscalculia ____ Dyspraxia ____ Dysraphia ____ Dyslexia ____ LPD ____ Memory
____ Language Processing Disorder ____ Non-Verbal Learning ____ Visual Perception/Visual Motor Deficit
____ Other: ____

HEALTH HABITS:

____ Yes ____ No Do you drink Alcohol? If yes, how much alcohol? ______________/ day/ week/ month
____ Yes ____ No Do you smoke cigarettes? If yes, how much and how often? _______/day _______ # years
____ Yes ____ No Do you have a history of substance abuse?
____ Yes ____ No Are you addicted to or abuse legal or illegal drugs?
____ Yes ____ No Do you drink caffeinated beverages? If yes, how much and how often? ________/day
____ Yes ____ No Do you have problems with eating or your appetite?
____ Yes ____ No Do you exercise regularly?
____ Yes ____ No Do you feel comfortable with your weight?
____ Yes ____ No Do you have trouble sleeping?
____ Yes ____ No Have you ever had a seizure?
____ Yes ____ No Do you have a history of head injuries or concussions? If yes, when ______________________________

CHILD/ADOLESCENT HEALTH HISTORY: *only if client is under the age of 18*

Who lives in the home? (Name, Age and Relationship)

____ Yes ____ No Are there pets in the home? If yes, what type? ____

PRENATAL HISTORY: (biological mother of minor client listed on page 1)

During Pregnancy	Yes	No	Describe
Medical conditions			
Emotionally stressful			
Tobacco/Cigarette Use			
Alcohol Use			
Substance/Drug Abuse			

Birth	Yes	No	Describe
Premature			
Full Term			
Vaginal Delivery			
C-Section			
Birth Weight			
Birth Injury			
Oxygen after delivery			
Admit to Newborn ICU			
Infection			
Jaundice			
Seizures			
Birth Defects			
Feeding Problems			
Post Partum Depression			
Other			

If you need to reschedule or cancel appointment (remember our 24-hour policy), please call our Client Care Specialists at 480-668-8301, x 1001.
If you need to reach our Billing Department (including questions about insurance), please call 480-668-8301, x 1003.
If you need to reach the Office Manager, please call 480-668-8301, x 1002.
We look forward to serving your behavioral health needs.

If you need immediate or emergency mental health care, please call the Behavioral Health Crisis Line at 602-222-9444.
THIS NUMBER IS NOT ASSOCIATED WITH FAMILY STRATEGIES COUNSELING CENTER.

FAMILY STRATEGIES
COUNSELING CENTER

CLIENT CONSENT - Please READ and SIGN

(Revised 4/1/20)

CONFIDENTIALITY

All sessions are completely confidential in accordance with law and recognized professional standards. If your counselor is required to communicate to another about your case, you must give written permission to do so. The only exception is, if in accordance with law and reasonable professional judgment, such communication appears needed to protect you or others from harm, or in response to legal process, or in other proper circumstances, the privileged nature of your communication ceased in these circumstances. Possible exceptions include, but are not limited to, the following situations: child abuse, abuse of the elderly or disabled, threats of suicide, and threats of homicide. Insurance companies are entitled to diagnosis, date, and type of service. All therapeutic services conducted will adhere to the laws of the state of Arizona and the Arizona Board of Behavioral Health; we are licensed within the state of Arizona and assert that services are being provided within the state of Arizona where the therapist resides and is licensed to practice.

INFORMED CONSENT

Therapy is an interactive process between client and therapist, and the results of therapy depend on your cooperation. It is meant to promote change and understanding. Sometimes this process can be emotionally painful, and at other times, very fulfilling. You will be expected to contribute to all decisions regarding therapeutic intervention devised for you, including out of session assignments. You have the right to refuse or alter any service and intervention. While the therapist will use best effort to assist you, there can be no assurances of results, and no promises can be made regarding the outcome of any service provided. You should question the rationale of any service, intervention, and discussion if these seem unclear to you. Your signature below indicates that you understand that there are risks for noncompliance with treatment recommendations, and that you will discuss these risks with your therapist.

E-THERAPY (i.e. TELEMEDICINE, TELETHERAPY, CYBERTHERAPY, etc.)

There are limitations and risks associated with e-therapy, including inherent confidentiality risks of electronic communication and potential for technology failure. If there is an emergency and the therapist is unavailable, you should call 9-1-1. If video is not available, the therapist will ask for identification. You will also be asked about your physical location during the telemedicine encounter, as well as verification that the setting provides for your confidentiality.

CLINICAL SUPERVISION

Your therapist ____________________________ is under clinical supervision as an associate licensed counselor with the Arizona Board of Behavioral Health, or is a University intern studying for a Masters Degree, and provides therapy under the clinical supervision of Floyd Godfrey, LPC, Kim Buck, LPC, or Matt Wheeler, LPC who are qualified to provide supervision within the state of Arizona according to the laws and regulations set forth by the Arizona Board of Behavioral Health. You can contact any of the above mentioned supervisors by calling 480-668-8301.

LITIGATION LIMITATION

The clinicians at Family Strategies Counseling Center, LLC are not trained for court reporting and testifying nor do they specialize in forensics. If you become involved in legal proceedings that require mandated participation by your therapist, you will be expected to pay for all professional time, including preparation and transportation time and costs, even if called to testify by another party regarding your case. Your therapist is not a court advocate and would be legally required to speak truthfully under oath. We highly recommend seeking outside counsel from forensically trained professionals with situations requiring court interaction, as we typically do not testify in court except under mitigating circumstances or court orders.

PAYMENT & MISSED APPOINTMENTS

Payment is expected at the time services are rendered, by cash, check or credit. If you are unable to keep an appointment, please notify your counselor as soon as possible. If an appointment is canceled or missed **without 24 hours prior notice, you will be billed at regular session fees.**

FINANCIAL RESPONSIBILITY

You (or responsible party) are considered responsible for payment of professional services. When you request to bill a third party, such as an insurance company, and that third party fails to make payment within 30 days from the date of billing, the client or responsible party is expected to pay within 10 days of receipt of the statement. Bills not paid within 30 days from the date of billing will be subject to an interest charge of 10% of the outstanding bill.

INFORMED CONSENT

I voluntarily agree to receive mental health assessment, care, treatment or services and authorize the undersigned therapist to provide such. I understand and agree that I will participate in the planning of these services and that I may stop such care at any time. By signing this consent form, I acknowledge that I have both read, understood and that I agree to all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification on anything unclear to me. I also acknowledge that I have received a copy of **"Client Rights"** and **"Complaint/Grievance Procedures"** as well as the **"Notice of Privacy Policies – HIPAA"** documents.

______________________________ ______________________________ ______________________________

(Client Signature) **(Print Name)** **Date**

______________________________ ______________________________

(Therapist Signature) **Date**

CONSENT FOR TREATMENT OF MINORS UNDER THE AGE OF 18

I, ______________________________ ______________________________ am the parent or legal guardian with legal custody

(Parent/ Guardian Signature) **(Print Name)**

of______________________________, and give permission to FSCS to provide counseling services for my child.

(Child Printed Name)

INSURANCE INFORMATION
FOR CLIENTS WITH BCBS COVERAGE ONLY

***DO NOT fill out this form unless you have BCBS coverage.**
We can submit claims to BCBS only for payment.

If your insurance carrier is not currently one with whom we contract,
your account will be considered "Self Pay" and will be billed accordingly.
If requested, a super bill can be provided that you can submit to your insurance company
for reimbursement for any out-of-network benefits you may have.

CLIENT INFORMATION

In addition to providing this information we will need to scan your insurance card and driver's license.

NAME: ____
Last, First Middle

GENDER: ___ Male ___ Female DATE OF BIRTH: ________________
(MM/DD/YYYY)

EMAIL: ______________________________ PHONE: ________________

MEMBER ID: __________________________ (include alpha letters)

GROUP #: ____________________________________ (list both **if** two are listed)

IS CLIENT THE PLAN HOLDER (PRIMARY SUBSCRIBER)? ___ Yes ___ No
If not, please complete information below in the "Primary Insured Information" section.

CLIENT'S EMPLOYER: ____________________________________

PLAN ADMINISTRATOR: *(as shown on card. Check back of card as well)* ____________________

PRIMARY INSURED INFORMATION

(Complete if primary insured is not the client. *All information is required*)

SUBSCRIBER'S NAME: ____
Last, First Middle

GENDER: ___ Male ___ Female

SUBSCRIBER'S DATE OF BIRTH: ______________________ (MM/DD/YYYY)

RELATIONSHIP TO CLIENT: __________________________

SUBSCRIBER'S EMPLOYER: ____________________________________

PLAN ADMINISTRATOR: *(as shown on card)* ______________________________

FAMILY STRATEGIES
COUNSELING CENTER

Authorization for Automatic Debit/Credit Card Charges

(updated 3/10/20)

Client Name: ____ **Phone:** ____________________

Parent/Guardian Name: (If applicable) ____

INDIVIDUAL THERAPY:

By my signature below, I authorize FAMILY STRATEGIES COUNSELING CENTER (Floyd Godfrey, LPC) to debit/charge the account number I have specified below:

* At the time of service when I check in at the front desk, OR
* For missed appointments**,** OR
* For late cancelations. (Late cancelations are defined as up to 24 hours prior to my appointment.)

Please be considerate of your therapist's time and abide by our 24-hour cancelation policy. If you notify us of a cancelation before 24 hours, it will allow us to schedule other clients seeking services here at Family Strategies.

Having a card on file to use for your sessions **is required** *and will enable us to expedite your check in time and reduce overhead allowing us to keep fees as low as possible.*

CHECK ONE BOX: ☐ USE FOR ALL SESSIONS ☐ USE FOR NO SHOWS OR LATE CANCELATIONS ONLY

CHECK ONE BOX: ☐ **YES** ☐**NO** MAY WE **PRECHARGE** YOUR CARD WHEN YOU ARE SCHEDULED AT A TIME WHEN NO RECEPTIONIST IS AVAILABLE AT THE FRONT DESK (i.e. Saturdays, late or early hours.)

GROUP THERAPY: If you join a group, this credit card will be charged for group fees as well ***unless you notify us otherwise*****.**

ONE WEEK'S WRITTEN NOTICE IS REQUIRED TO CANCEL THIS AUTHORIZATION

SIGNATURE : ____**DATE:** ______________________

CREDIT CARD INFORMATION: **Please check box:** ☐**VISA** ☐**MasterCard** ☐**Discover Card** ☐**Amex**

Name as it appears on the card: ____

Credit Card #: ____

Expiration Date: _______ CVV# *on the back of the card*: _______ **IS THIS AN HSA CARD?** __________

THIRD-PARTY PAYERS: If a third party pays for all or a portion of your session fees, **we must have a signed Third-Party Agreement on file for you**. Please ask for this form at the front desk from the receptionist. Your credit card will not be charged unless your account is 60 days past due or beyond. We will contact you before charging your card.

Third-Party Payer Name: ___________________________________ Relationship to You: ___________

Address: ____

Street City State Zip

Phone: ______________ Third-Party Payer Email: ____

FAMILY STRATEGIES
COUNSELING CENTER

CLIENT RIGHTS

Arizona Statutes R9-10-1907, Office of Medical Licensing, requires that at the time of your initial appointment you be informed of your rights as a client and, if applicable, the client's parent, guardian, custodian, designated representative, or agent receive a copy of this document.

All clients shall be afforded the following basic rights:

1. The right to be treated with dignity, respect, and consideration;

2. The right to **not** be subjected to:
    a. Abuse;
    b. Neglect;
    c. Exploitation;
    d. Coercion;
    e. Manipulation;
    f. Sexual abuse;
    g. Sexual assault;
    h. Restraint or seclusion;
    i. Retaliation for submitting a complaint to the Department or another entity; or
    j. Misappropriation of personal and private property by a counseling facility's personnel member, employee, volunteer, or student; and

3. A patient, or the patient's representative, has the right to:
    a. Either consents to or refuses counseling;
    b. Refuse or withdraw consent for receiving counseling before counseling is initiated;
    c. Is informed of the following:
        i. The counseling facility's policy on health care directives, and
        ii. The patient complaint process;
    d. Consent to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted to a counseling facility for identification and administrative purposes; and
    e. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
        i. Medical record, or
        ii. Financial records.

4. The right to **not** to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;

5. The right to receive counseling that supports and respects the patient's individuality, choices, strengths, and abilities;

6. The right to receive privacy during counseling;

7. The right to review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;

8. The right to receive a referral to another health care institution if the counseling facility is not authorized or not able to provide the behavioral health services needed by the patient;

9. The right to participate, or have the patient's representative participate, in the development of, or decisions concerning, the counseling provided to the patient;

10. The right to participate or refuse to participate in research or experimental treatment; and

11. The right to receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

12. The right to review, upon written request, the client's own record during the agency's hours of operation or a time agreed upon by the clinical director, except as described in R9-20-211(A)(6).

13. The right to review the following at the agency or at the "Department": the A.A.C. Title 9, Chapter 20 Rules; the report of the most recent inspection of the premises conducted by the "Department"; a plan of correction in effect as required by the "Department"; if the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the "Department", the most recent report of inspection conducted by the nationally recognized accreditation agency; and if the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the "Department", a plan of correction in effect as required by the nationally recognized accreditation agency.

14. The right to be informed of all fees that the client is required to pay and of the agency's refund policies and procedures before receiving a behavioral health service, except for a behavioral health service provided to a client experiencing a crisis situation.

15. The right to receive a verbal explanation of the client's condition and a proposed treatment, including the intended outcome, the nature of the proposed treatment, procedures involved in the proposed treatment, risks or side effects from the proposed treatment, and alternatives to the proposed treatment.

16. The right to be offered or referred for the treatment specified in the client's treatment plan.

17. The right to receive a referral to another agency if the agency is unable to provide a behavioral health service that the client requests or that is indicated in the client's treatment plan.

18. The right to give general consent and, if applicable, informed consent to treatment, refuse treatment or withdraw general or informed consent to treatment, unless treatment is ordered by a court according to A.R.S. Title 36, Chapter 5, is necessary to save the client's life or physical health, or is provided according to A.R.S. 36-512.

19. The right to be free from: abuse; neglect; exploitation; coercion; manipulation; retaliation for submitting a complaint to the "Department" or another entity; discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the client's treatment needs, except as established in a fee agreement signed by the client or the client's parent, guardian, custodian, or agent; treatment that involves the denial of: food, the opportunity to sleep, or the opportunity to use the toilet; and restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.

20. The right to participate or, if applicable, to have the client's parent, guardian, custodian or agent participate in treatment decisions and in the development and periodic review and revision of the client's written treatment plan.

21. The right to control the client's own finances except as provided by A.R.S. 36-507(5).

22. The right to participate, or refuse to participate, in religious activities.

23. The right to refuse to perform labor for an agency, except for housekeeping activities and activities to maintain health and personal hygiene.

24. The right to be compensated according to state and federal law for labor that primarily benefits the agency and that is not part of the client's treatment plan.

25. The right to participate, or refuse to participate, in research or experimental treatment.

26. The right to give informed consent in writing, refuse to give informed consent, or withdraw informed consent in writing, refuse to give informed consent, or withdraw informed consent to participate in research or treatment that is not a professionally recognized treatment.

27. The right to refuse to acknowledge gratitude to the agency through written statements, other media, or speaking engagements at public gatherings.

28. The right to receive behavioral health services in a smoke-free facility, although smoking may be permitted outside the facility.

COMPLAINT / GRIEVANCE PROCEDURE

There is an established process for resolving client complaints at Family Strategies & Coaching. In the event you are dissatisfied with the services you have received please:

1. Contact your counselor and advise them of your complaint. If not satisfied, contact:

2. The Executive Director of Family Strategies & Coaching, Floyd Godfrey at (480) 668-8301, extension 1. You may make your complaint by phone, mail, or in person. If the Executive Director is not available, you may contact the Assistant Director at (480) 668-8301, and leave a message if necessary.

Every effort will be made to call you as soon as possible that same working day. Complaints must be filed within 6 months of your last appointment. The complaint will be reviewed within 14 working days.

3. Once a decision is made on your complaint, you will be notified of the outcome within 30 days. If you are not satisfied, you may then contact:

Arizona Department of Health Services
Office of Medical Licensing
150 North 18th Avenue, Suite #410, Phoenix, AZ 85007
(602) 364-2595

Division of Behavioral Health Services
150 North 18th Avenue, Suite #200, Phoenix, AZ 85007
(602) 364-4585

All Family Strategies Counseling Center Policies and Procedures, and documented reports are available for review upon request by appointment by calling (480) 668-8301.

OFFICE OF BEHAVIORAL DIVISION OF BEHAVIORAL OFFICE OF HUMAN RIGHTS ADVOCATES

HEALTH LICENSING HEALTH SERVICES
150 N. 18th Ave., 2nd Floor
Phoenix, AZ 85007 Phoenix, AZ 85007
602-364-4585

ARIZONA DES CHILD PROTECTIVE SERVICES
P.O. Box 44240
Phoenix, AZ 85064-4240
888-767-2445

ARIZONA DES ADULT PROTECTIVE SERVICES
1789 W. Jefferson St
Phoenix, AZ 85007
877-767-2385

ARIZONA CENTER FOR DISABILITY LAW
5025 E. Washington St, Suite 202
Phoenix, AZ85034
602-274-6287

REGIONAL BEHAVIORAL HEALTH AUTHORITY:
MAGELLAN HEALTH SERVICES OF ARIZONA (Maricopa County)
4801 E. Washington St., Suite 100,
Phoenix, AZ 85034
800-564-5465

FAMILY STRATEGIES
COUNSELING CENTER

Notice of Privacy Policy – HIPAA

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

I. PROTECTED HEALTH INFORMATION (PHI): Family Strategies understands the importance of protecting health information about our clients. Our practice creates records of care and services provided by therapists. These records are to provide our clients with quality care as well as to comply with certain legal requirements. This notice is to inform you of the ways in which we may use and disclose health information about you as well as to inform you of legal obligations to disclose. Your clinician is required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- Family Strategies can change the terms of this Notice, and such changes will apply to all information we have about you. The new Notice will be available upon request.

II. HOW FAMILY STRATEGIES MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose health information.

For Treatment, Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. This includes coordination with third party providers for referrals and consultations from one health care provider to another.

Family Strategies as an agency requires monthly staffing with clinicians. Your protected health information may be used in coordination of staffing within the agency to provide quality care.

Lawsuits and Disputes: If you are involved in a lawsuit, we may disclose health information in response to a court or administrative order. We may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. Family Strategies maintains "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

   a. For use in treating you.

   b. For use in defending Family Strategies/Clinicians in legal proceedings instituted by you.

   c. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.

   d. Required by law and the use or disclosure is limited to the requirements of such law.

   f. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. Family Strategies will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. Family Strategies will not sell your PHI in the regular course of my business.

4. Even if you do have a signed authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures not needed of your PHI.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, Family Strategies can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law and the use or disclosure complies with, and is limited to, the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although the first priority is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on our premises.
6. Appointment reminders and health related benefits or services. We may use and disclose your PHI to contact you to remind you that you have an appointment with me. We may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that we offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask not to use or disclose certain PHI for treatment, payment, or health care operations purposes.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How We Send PHI to You. You have the right to ask us to contact you in a specific way or to send mail to a different address, and we will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that we have about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and we may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures We Have Made. You have the right to request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided us with an Authorization. We will respond to your request for an accounting of disclosures within 60 days of receiving your request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that the correction of the existing information or add the missing information.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

VII. FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS WERE VIOLATED

1. You can complain if you feel we have violated your rights by contacting us at Family Strategies Counseling Center: 1745 South Alma School Rd, Mesa, AZ 85210, calling 480-668-8301, or emailing at admin@familystrategies.org.
2. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1- 877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
3. You will not be retaliated against for filing a complaint.

EFFECTIVE DATE OF THIS NOTICE: This notice went into effect on March11, 2020