Client Name: DOB: Medicaid #: Record #:

Safe Haven Child & Family Counseling Services

233 Sharon Amity Rd., Suite 102 Charlotte, NC 28211
1003 West Meeting St. Lancaster, SC 29720
(980)613-8474

CLIENT REGISTRATION INFORMATION

Appointment Date:_____ Clinician Name:_____

Last Name:_____ First:_____ Middle:_____
(Full Legal Name)

Sex:_____ Date of Birth:_____ Age:_____ Place of Birth:_____
(City/State)

Home Address:_____ Apt #:_____

City:_____ State:_____ Zip Code:_____ Home Phone #:_____

Social Security #_____ Mother's Maiden Name:_____

Religious Preference:_____ Name of Church:_____

ALLERGIES:_____

Name of School Attending:_____Current Grade:_____

DID SOMEONE REFER YOU TO OUR FACILITY? _____Yes ___✔___No

Please give us your Referral Source: Name:_____ Agency:_____

RESPONSIBLE PARTY: **(Must be Parent, Legal Guardian or DSS Worker)**

Last Name:_____ First:_____ Middle:_____
(Full Legal Name)

Sex:_____ Date of Birth:_____ Age:_____ Place of Birth:_____
(City/State)

Home Address:_____ Apt #:_____

City:_____ State:_____ Zip Code:_____ Home Phone #:_____

Social Security #_____ Mother's Maiden Name:_____

Employer:_____ Employer's Phone Number:(__)_____

Employer's Address:_____

Position/Occupation:_____ Household Income:_____
(Annual/Monthly/Hourly)

Total Household Income (Including Spouse):_____

Client Name: DOB: Medicaid #: Record #:

Total # of Dependents (Including Self)

EMERGENCY CONTACT INFORMATION: (Parent, Grandparent, Relative, or Friend)

Last Name:_____ First:_____ Middle:_____
(Full Legal Name)

Relationship:_____ Home Phone: ( )_____ Work: ( )_____

Home Address:_____ Apt.#_____

City:_____ State:_____ Zip Code:_____ Home Phone #:( )_____

SOURCE OF INCOME (CIRCLE ONE BELOW)

⊙EMPLOYMENT ○PENSION ○SOCIAL SECURITY ○SSI ○AFDC ○OTHER

INSURANCE INFORMATION: PLEASE PRESENT YOUR INSURANCE CARDS AT THE TIME OF SERVICES (A COPY WILL BE MADE)

(PLEASE CHECK ONE BELOW)

Do you have: ✔Medicaid (What State?____) ✔Medical Insurance ✔Medicare

✔Champus ✔Other ✔No Insurance

INSURANCE TO BE BILLED FIRST (PRIMARY):

Insurance Company Name:_____

Policy Holder's Name:_____
(Last / First / Middle)
Date of Birth:____/____/____ Policy Holder's Social Security Number:_____

Policy Number:_____ Group Number:_____

Insurance Company Telephone Number (Customer Service):_____

Pre-certification Telephone Number (Authorization Number):_____

Billing Address for Claims:_____

INSURANCE TO BE BILLED SECOND (SECONDARY)

Insurance Company Name:_____

Policy Holder's Name:_____
(Last / First / Middle)
Date of Birth:____/____/____ Policy Holder's Social Security Number:_____

Policy Number:_____ Group Number:_____
Insurance Company Telephone Number (Customer Service):_____

Client Name: DOB: Medicaid #: Record #:

Pre-certification Telephone Number (Authorization Number):_____

Billing Address for Claims:_____

Comments for Office Use Only:

*****PLEASE READ ALL ATTACHED OUTPATIENT FORMS (Consent for Treatment) AND SIGN WHERE INDICATED (REQUIRES LEGAL GUARDIAN SIGNATURE).**

Client Name: DOB: Medicaid #: Record #:

Safe Haven Psychotherapy Agreement

In order to provide effective treatment these terms must be followed:

The client should attend each scheduled appointment unless a 24-hour cancellation notice is provided.

The client should be honest regarding information that will assist in treatment.

The client should communicate any problems that may occur during the course of treatment with therapist.

The therapist will also abide by these terms as well.

If these terms are not followed then therapy may be terminated.

Client:_____ Date:_____

Therapist:_____Date:_____

Client Name: DOB: Medicaid #: Record #:

Release of Information & Authorization of Payment

I hereby agree to release information to Medicaid regarding _____.

For purposes of coordination of services, I am also agreeing to pay all charges not covered by insurance or Medicaid.

Patient:_____ Responsible Party:_____

Client Name: DOB: Medicaid #: Record #:

Safe Haven Child & Family Counseling Services

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Dear Client and Family:

I really appreciate your business and look forward to providing services to you and your family. However, when appointments are scheduled for clients that time is no longer available to anyone else, but when that appointment is not kept, it is not beneficial to the client or the agency. The agency has experienced a high number of "no shows" (missed appointments) and, as a result, has been forced to charge a fee of $50.00 for appointments that are not cancelled or rescheduled 24 hours before the scheduled appointment. This new policy will become effective May 1, 2012. There will be no exceptions unless extreme circumstances exist. Once again, I appreciate your business and look forward to providing you with the best of services.

Sincerely,

Cossandra E. Miller, CEO, LCSW

Client Name: DOB: Medicaid #: Record #:

Safe Haven Child & Family Counseling Services

233 Sharon Amity Rd., Suite 102 Charlotte, NC 28211
1003 West Meeting St. Lancaster, SC 29720
(980)613-8474

Safe Haven has permission to provide treatment to my child, _____,
in the form of individual, group, and family psychotherapy.

I am hereby giving my permission to allow treatment of my child.

Signature:_____ Date:_____

Cossandra Miller, MSW, LCSW
Safe Haven Child & Family Counseling Services
233 Sharon Amity Rd., Suite 102 Charlotte, NC 28211
1003 West Meeting St. Lancaster, SC 29720
(980)613-8474

I am pleased you have selected me as your counselor. This disclosure is intended to inform you about my background and to ensure that you understand our professional relationship.

I am the owner of Safe Haven Child and Family Counseling Services. I graduated from the University of South Carolina with a bachelor in Criminal Justice and a graduate degree in Social Work. I am a Licensed Clinical Social Worker. My experiences include the roles of a Pediatric Social Worker and a Child/Adolescent/Family Therapist. Specialties include treating disorders in the child/adolescent and developmentally delayed population. I am dedicated to helping children and their families overcome obstacles that prevent them from enjoying healthy lives. I understand the challenges of raising a family as the mother of three children.

COUNSELING SERVICES OFFERED/THEORETICAL APPROACHES

People can make better decisions if they have enough information and understand how something works. The technical term used in this field is "Informed Consent." Here are some aspects of counseling and therapy as I see and practice it:

Counseling includes your active involvement as well as efforts to change your thoughts, feelings and behaviors. You will have to work both in and out of the counseling session. There are no instant, painless, or passive cures. Instead there may be homework assignments, exercises, writings, journals entries, role-plays, etc. Most likely, you will be challenged to work on relationships and make long-term efforts. Sometimes change will be easy and swift, but more often it will be slow and deliberate; effort may need to be repeated.

My psychotherapeutic approach with individuals is based on Cognitive Behavioral

Therapy. Cognitive Behavioral Therapy approach that addresses dysfunctional emotions, maladaptive behaviors and cognitive processes and contents through a number of goal oriented, explicit systematic procedures. This approach generates awareness of thoughts and their effects, it assists with making positive changes in their thoughts, beliefs, and assumptions by enhancing their self observational powers. It also brings attention to the effect of negative behaviors in the maintenance of their problems. As a client, you are encouraged to become knowledgeable about goals, methods, and effectiveness.

If we are to work together we will need to specify the goals, methods, the risks and benefits of treatment, the approximate time involved, the costs, and other aspects of your particular situation. Before going further, I would like us to agree on a plan that we both feel comfortable in participating. Periodically, we will evaluate your progress and if necessary, redesign your treatment plan, goals, and methods.

As with any intervention, there are both benefits and risks associated with counseling and therapy. Risks include experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger or frustration, or having difficulties with other people. Some changes may lead to what seems to be worsening circumstances or even losses (for example, counseling will not necessarily keep a marriage intact). However, the clients I work with are psychologically and emotionally "healthy" and seek counseling for difficulties due to normal life events. I do not take on clients whom, in my professional opinion, I cannot help using the techniques I have available. I will enter our relationship with optimism and an eagerness to work with you.

CONFIDENTIALITY

I regard the information you share with me with the greatest respect, so I want us to be as clear as possible about how it will be handled. Generally, I will tell no one what you tell me. The privacy and confidentiality of our conversations, and my records, is a privilege of yours and is protected by state law and my profession's ethical principles. However, exceptions to confidentiality exist. These include, but are not limited to: (1)

when I believe you intend to harm yourself or another person; (2) when I believe a child or elder person has been or will be abused or neglected; (3) you disclose sexual contact with another mental health professional with whom you had a professional therapeutic relationship, in which case I must file a complaint and you have a right to confidentiality in the filing of the complaint; (4) I may need to consult with another professional (usually a supervisor who holds a counseling credential) about your concerns and how I might proceed in order to help you, and will do so without using your name. In rare circumstances, Professional Counselors can be ordered by a judge to release information, i.e.: child custody/probation cases. Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S. 130A-143. Whenever authorization is required for the release of this information, the consent shall specify that the information to be released includes information relative to HIV infection, AIDS or AIDS related conditions.

Otherwise, I will not tell anyone anything about your treatment, diagnosis, history, or even that you are a client, without your full knowledge and usually a signed release form.

EXPLANATION OF DUAL RELATIONSHIPS

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Therefore, our contact will be limited to sessions you will arrange with me (for example, it would be inappropriate to invite me to social gatherings). You will be best served while I am seeing you for counseling and therapy if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns. You will learn a great deal about me as we work together during your counseling experience. However, it is important for you to remember that you are experiencing me in my professional role.

LENGTH OF SESSIONS

I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards. Unless we agree to a different amount of time, individual counseling sessions are 45-55 and 30 minutes in duration, and will not be extended if you

happen to arrive late. Treatment length will vary from 3 to 12 months depending on the individual's progress towards his/her goals (Length of treatment is subject to change depending on re-evaluation of goals based on client and therapist input and if medically necessary deemed appropriate by Value Options or Mecklink Behavioral Health). We will schedule our sessions for our mutual agreement. If you are unable to keep an appointment please call to cancel or reschedule at least 24 hours in advance. If I do not receive such notice, you will be responsible for paying for a no show fee of $50.00. *Please note that it is impossible to guarantee any specific results regarding your counseling goals*. However, together we will work to achieve the best possible results for you.

Also, I have the right to postpone/terminate our work together if any of the following circumstances occur: (1) if you come to the session under the influence of alcohol and/or drugs; (2) if I believe you are not benefiting from counseling. In all of the aforementioned cases involving termination, I will provide you with referrals. If you choose to decline the referrals, I will terminate our counseling relationship, nevertheless.

METHODS OF PAYMENT

Currently Safe Haven Child and Family Counseling Services, LLC. accepts Medicaid, NC Health Choice, NC Blue Cross and Blue Shield (out-of-network), Medicare and Self-pay consumers who pay costs out-of-pocket. If you have other insurance, you will have to pay for sessions at the time services are rendered and you will be reimbursed as your Insurance Company pays Safe Haven Child and Family Counseling or you directly. A sliding scale with a specific number of reduced and Pro Bono slots are available as well. The current rates for psychotherapy are as follows: intake $125.00, 45-50 minute session $95.00, and 30 minute session $40.00. My intention is to provide professional and affordable counseling to all my clients.

ELECTRONIC COMMUNICATION POLICY

E-MAILS, TEXT MESSAGES, COMPUTERS AND FAXES**:** It is very important to be aware that computers, e-mails, faxes and text message communications can be relatively easy to access by unauthorized people and hence can compromise the

privacy and confidentiality of such communication. If you communicate confidential or highly private information via e-mail or text message, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and I will honor your desire to communicate electronically. However, I may communicate appointment issues or send forms that have been discussed in therapy with you. I will not use your/your child's name but will use initials or no name at all. Please, be aware that e-mails are part of the medical records. Please do not use e-mail for emergencies. Due to computer or network problems e-mails may not be deliverable, and I may not check my email daily.

COMPLAINT PROCEDURES

If you are dissatisfied with any aspect of our work, please inform me immediately. This will make our work together more efficient and effective. If you think that you have been treated unfairly or unethically, be it me or any other counselor, and cannot resolve this problem with me, you can contact the North Carolina Board of Social Work Certification and Licensure Board PO Box 1043 Asheboro, NC 27204 Phone (336) 625-1679; (800)550-7009, for clarification of client's rights as I've explained them or even to lodge a complaint. You may also contact, Cardinal Innovations at 1-800-939-5911**,** Governor's Advocacy Council for Persons with Disabilities is a statewide agency established to protect and advocate for the rights of persons with disabilities1-800-326-3842, and NC Mental Health Consumer's Organization, Inc.is a non-profit, non-governmental, organization made up of mental health consumers who provide peer support and advocacy for mental health clients 1-800-662-8706.

Client Name: DOB: Medicaid #: Record #:

Client's Rights

- You have the right to treatment, including access to medical care and habilitation, regardless of age or degree of mental illness, developmental disabilities, or substance abuse GS 122C-51.
- You have the right to an individualized written treatment or habilitation plan setting forth a program to maximize the development or restoration of his capabilities GS 122C-51.
- You have the right to confidentiality GS 122C-52.
- You have the right to review your own record GS 122C-53.
- You have the right to treatment and consent to treatment GS 122C-57
- You have the right to withdraw consent or refuse services at any time GS 122C-57

Safe Haven Child and Family Counseling has permission to provide treatment to_____ in the form of individual, family, and group psychotherapy.

- I hereby give my consent for treatment.
- I have been informed of my right to terminate/refuse treatment at my discretion with the full knowledge of the risks/benefits being disclosed by Safe Haven Child and Family Counseling.
- I have been informed that Safe Haven Child and Family Counseling will provide a referral to an alternative provider to render Mental Health treatment such as counseling and/or emergency assistance through Carolinas Medical Center-Randolph Hospital or a hospital of client's choice if services or terminated/refused prior to discharge.

If you have any questions, feel free to ask. Please sign and date both copies of this form. A copy of your records will be returned to you. I will retain a copy in my confidential records. This agreement shall be effective for 1 year.

Counselor's Signature _____Date_____

Client's Signature _____Date_____

Guardian's Signature _____Date_____

Client Name: DOB: Medicaid #: Record #:

Safe Haven Child & Family Counseling Services

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED INFORMATION

This form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (445 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C).Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure.

PURPOSE (Two- way consent)

☑ Ongoing communication	☐ Copy of record ☑ Legal or Insurance review	☑ Other

RELEASE FROM: _____

Facility, agency or person listed above is authorized to release information

_____

Agency Address: **Agency Telephone Number** **Agency Fax Number**

Specific Information To Be Released

From: (MM/DD/YY) To: (MM/DD/YY) (Does not exceed 1 year) _____

☑ All records & Details

☑ Other (Please specify) _____

Describe purpose of the requested use or disclosure

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immune deficiency virus (HIV).

Name of Consumer Whose Information if to be released:

Name: _____
First Middle Last

Address: _____ SSN#: _____
(Street/ PO Box, City ,State, Zip)

Date of Birth: _____ Phone number: _____
(MM/DD/YYYY) Home/ cell/ work (best number to reach)

RELEASE TO: The following individuals/ organizations my use the information released. A separate authorization must be completed if the information or purpose differs from individuals/organization listed below:

Name ***Address*** ***Telephone/Fax#***
Relationship

Safe Haven Child and Family Counseling Services, LLC 233 S. Sharon Amity Rd. Suite 102 Charlotte, NC 28211 704-763-9555, (f) 980-613-8474

_____

_____

Patient's Rights , *Revocation and Expiration*

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. [If I want to revoke this authorization, I must do so in writing.] I may request to inspect or obtain a copy of the information used and disclosed per Safe Haven Child and Family's Notice of Privacy Practices/Policy. I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that Safe Haven Child and Family cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits on my refusal to sign. This **authorization will expire** when the requested health information noted in specific information section above is release to the recipient named in this document and the purpose of the release is satisfied.

SIGNATURES

Signature of consumer: _____ Date_____

Please print name: _____

Signature of legally responsible person or other personal representative
(If required):_____ Date_____
Please print name:_____

Please explain representative's authority to act on behalf of
consumer:_____

Client Name: DOB: Medicaid #: Record #:

SAFE HAVEN CHILD AND FAMILY

"When Quality Matters"

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

WE ARE REQUIRED BY LAW TO PROTECT HEALTH CARE INFORMATION ABOUT YOU.

WE ARE REQUIRED BY LAW TO PROTECT HEALTH CARE INFORMATION (2)

ABOUT YOU.

We are required by law to protect the privacy of health care information about you and health care information that identifies you. This may be information about health care services that we provide to you or payment for health care provided to you. It may also be information about your past, present, or future health care condition.

We are required by law to provide you with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to health care information. Safe Haven Child and Family and other health care providers are legally bound to follow the terms of this Notice.

Safe Haven Child and Family has executed a Business Associate Agreement with the Area Program/LME which for the purpose of treatment and operations we may be required to disclose protected health information, except when prohibited pursuant to State and Federal laws. We may disclose to these Business Associate entities information without your consent to obtain legal or financial services, or to another medical facility to provide health care to you, as long as there is a Business Associate Agreement in place. In connection with our Business Associates, they have an independent responsibility to comply with all HIPAA Privacy regulations as it relates to disclosure of protected health information.

In other words, we are only allowed to use and disclose health care information in the manner that we have described in this Notice.

We may change the terms of this Notice in the future. We reserve the right to make changes and to make the new Notice effective for <u>all</u> health care information that we maintain. If we make changes to this Notice, we will:

- Post the new Notice in our main office or other prominent location

(3)

- Have copies of the new Notice available upon request (you may also contact our Executive Director and/or designee at 704-763-9555 to obtain a copy of the current Notice)

The rest of this Notice will:

- Discuss how we may use and disclose health care information about you
- Explain your rights with respect to health care information
- Describe how and where you may file a privacy-related complaint

If, at any time, you have questions about information in this Notice or about our privacy policies, procedures or practices, you may contact our Executive Director and/or designee at 704-763-9555.

WE MAY USE AND DISCLOSE HEALTH CARE INFORMATION ABOUT YOU IN SEVERAL CIRCUMSTANCES

This section of our Notice explains in some detail how we may use and disclose health care information about you in order to provide health care, obtain payment for that health care, and operate our business efficiently. This section then briefly mentions several other circumstances in which we may use or disclose health care information about you. For more information about any of these uses or disclosures, or about any of our privacy policies, procedures or practices, you may contact our Executive Director and/or designee at 704-763-9555.

1. Treatment

Safe Haven Child and Family may use and disclose health care information about you to provide health care treatment to you except as prohibited by State and Federal law. In other words, we may use and disclose health care information about you to provide, **(4)**

coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others.

We will use your health information for treatment.

Example: Information obtained about you by a clinical staff member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will also record goals that you established and the interventions used to help you reach your goals. Your assigned psychiatrist will also record information about

medications they have prescribed for you as well as your response to these medications.

We may use and/or disclose health care information about you in order to inform you of or recommend new treatment or different methods for treating a health care condition that you have or to inform you of other health related benefits and services that may be of interest to you.
Example: Jane is a consumer at our agency and she has been diagnosed with oppositional defiant disorder. The agency has developed an educational program to help consumers manage their lifestyle. The group home sends Jane's legal responsible person a flyer with information about the program.

We may also use and/or disclose health care information about you to send you and/or legal responsible person reminders about your appointment.

2. Payment

Safe Haven Child and Family except as prohibited by State and Federal law, may use and disclose health care information about you to obtain payment for health care services that you received. This means that, within the agency, we may use health care information about you to arrange for payment (such as preparing billing and managing accounts). We also may disclose health care information **(5)**

about you to others (such as insurers, collection agencies, and/or consumer reporting agencies) except as prohibited by State and Federal regulations. In some instances, we may disclose health care information about you to an insurance plan before you receive certain health care services because, for example, we may
want to know whether the insurance plan will pay for a particular service.
We will use your health information for payment.

Example: A bill will be sent to you and/or a third-party payer. Information on or accompanying the bill may include information that identifies you as well as your diagnosis, your treating clinician and the type of services you have received.

3. Health care operations

Safe Haven Child and Family except as prohibited by State and Federal law, may use and disclose health care information about you in performing a variety of business activities that we call "health care operations". These "health care operations" activities allow us to, for example, improve the quality of care we provide and reduce health care costs. For example, we may use or disclose health care information about you in performing the following activities:

- Reviewing and evaluating the skills, qualifications, and performance of health care providers taking care of you;
- Providing training programs for students, trainees, health care providers or non-health care professionals to help them practice or improve their skills;
- Reviewing and improving the quality, efficiency and cost of care that we provide to you and our other consumers;
- Improving health care and lowering costs for groups of people who have similar health problems and helping manage and coordinate the care for these groups of people.
- Cooperating with outside organizations that assess the quality of the care provided, including government agencies and private organizations;

- Planning for our organization's future operations;
- Resolving complaints, grievances, and appeals within our organization and/or contract agencies;
- Reviewing our activities and using or disclosing health care information in the event that control or our organization significantly changes;

- Working with others (such as lawyers, accountants, or other providers) who assist us to comply with this Notice and other applicable laws.

We will use your health information for health care operations.
Example: Members of the treatment team(s) and Quality improvement staff may use information in your health record to assess the care and outcomes in your case. This information will then be used in an effort to continually improve the quality and effectiveness of the services we provide. We will use your health information to enter data for billing and documentation purposes. We may also contact you via telephone or letter to provide appointment reminders.

4. Persons Involved in Your Care

Safe Haven Child and Family except as prohibited by State and Federal law, may disclose health care information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care except as mandated by State and Federal regulations. If the consumer is a minor, we may disclose health care information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances. For more information on the privacy of a minor's information, contact our Executive Director and/or designee at 704-763-9555.

(7)

We may also use or disclose health care information about you to a relative, another person involved in your care or possibly a disaster relief organization (such as the Red Cross) if we need to notify someone about your location or condition.

You may ask us at any time not to disclose health care information about you to persons involved in you care. We will agree to your request and not disclose the information except in certain limited circumstances (such as emergencies) or if the consumer is a minor. If the consumer is a minor, we may or may not be able to agree with your request.
Example: Jane's husband regularly comes to the mental health center with Jane for her appointments and he helps her with her medication. When the nurse is discussing a new medication with Jane, Jane invites her husband to come into the private room. The nurse discusses the medication with Jane and Jane's husband.

5. Storage of medical records
All records are maintained in a locked fire proof file cabinet behind two locked doors on premises. Only authorized personnel have access to medical records who have been appropriately trained. Only authorized individuals will transport secured copied medical records in a lock box for the purpose of the intended use. Electronic confidential data is stored on a file server that can only be accessed by authorized individuals. Medical records (duplicates) that are no longer in use are properly shredded and disposed. Medical records are maintained and stored for 30 years.

6. Required by law.

We will use and disclose health care information about you whenever we are required by law to do so. There are many State and Federal laws that require us to use and disclose health care information. For example, State law requires us to report suspected communicable disease to the health department and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those State laws with other applicable laws.

7. National priority uses and disclosures

When permitted by law, we may use or disclose health care information about you without your permission for various activities that are recognized as "national priorities." In other words, the government has determined that under certain circumstances (described below), it is important to disclose health care information that it is acceptable to disclose without the individual's permission. We will only disclose health care information about you in the

following circumstances when we are permitted to do so by law. For more information on these types of disclosures, contact our Executive Director and/or designee at 704-763-9555.

- **Threat to health or safety:** We may use or disclose health care information about you if we believe it is necessary to prevent or lessen a serious threat to health or safety.
- **Public health activities:** We may use or disclose health care information about you for public health activities. Public health activities require the use of health care information for various activities, including but not limited to, activities related to investigating diseases, reporting child abuse and neglect, monitoring drugs or devices regulated by the Food and Drug Administration, and monitoring work-related illnesses or injuries. For example, if you have been exposed to a communicable disease (such as a sexually transmitted disease), we may report it to the State and take other actions to prevent the spread of disease.
- **Abuse, neglect, or domestic violence:** We may disclose health care information about you to a governmental authority (such as the Department of Social Services) if you are an adult and we reasonably believe that you may be a victim of abuse, neglect, or domestic violence.
- **Health oversight activities:** We may disclose health care information about you to a health oversight agency-which is basically an agency responsible for overseeing the health care

system or certain governmental programs. For example, a government agency may request information from us while they are investigating possible insurance fraud.

- **Court proceedings:** We may disclose health care information about you to a court or an officer of the court (such as an
- attorney) with an appropriate order from a judge. For example, we would disclose health care information about you to a court if a judge orders us to do so.

(9)

- **Law Enforcement:** We may disclose health care information about you to law enforcement officials for specific law enforcement purposes. For example, we may disclose limited health care information about you to the police officer if the officer needs the information to help find or identify a missing person.

- **Worker's compensation:** We may disclose health care information about you in order to comply with workers' compensation law.
- **Certain government functions:** We may use or disclose health care information about you for certain government functions, including but not limited to military and veteran's activities and national security and intelligence activities. We may also use or disclose health care information about you to a correctional institution in some circumstances.

8. Authorization

Other than the uses and disclosures described above (#1-6), we will not use or disclose health care information about you without the "authorization" by you or your legally responsible person. In some instances, we may wish to use or disclose health care information about you and we may contact you to ask you to sign an authorization form. You may contact us to ask us to disclose health care information and we will ask you to sign an authorization form.

If you sign a written authorization allowing us to disclose health care information about you, you may later revoke (or cancel) your authorization in writing (except information which has already been released, or in very limited circumstances, related to obtaining insurance coverage). If you would like to revoke your authorization, you may write us a letter revoking your authorization or fill out an Authorization Revocation Form. Authorization Revocation Forms are

(10)

available from our Executive Director or assigned staff member. If you revoke your authorization, we will follow your instructions, except to the extent that we have already relied upon your authorization and taken some action.

YOU HAVE RIGHTS WITH RESPECT TO HEALTH CARE INFORMATION ABOUT YOU

This section of the Notice will briefly mention each of these rights. If you would like to know more about your rights, please contact our Executive Director and/or designee at 704-763-9555.

1. Right to a copy of this Notice

You have a right to have a paper copy of our Notice of Privacy Practices at any time. In addition, a copy of this Notice will always be posted in our waiting area or other prominent locations. If you would like to have a copy of our Notice, ask the receptionist for a copy or contact our Executive Director and/or designee at 704-763-9555.

2. Right of access to inspect and copy

You have the right to inspect (which means see or review) and to receive a copy of health care information about you that we maintain in certain groups of records. If you would like to inspect or receive a copy of health care information about you, you must provide us with a request in writing. Our agency must act on this request no later than 30 days after receipt of this request.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. We will also inform you in writing if you have the right to have our decision reviewed by another person.

If you would like a copy of the information, we may charge you a fee to cover the costs of the copy. We may be able to provide you with a summary or explanation of the information. Contact our Executive

Director and/or designee for more information on these services and any possible additional fees.

3. Right to have health care information amended
You have the right to have us amend (which means correct or add) health care information about you that we maintain in certain groups of records. If you believe that we have information that is either inaccurate or incomplete, we may amend the information to indicate the problem and make reasonable efforts to notify others who have copies of the inaccurate or incomplete information. Our agency must act on this request no later than 60 days after receipt of the request.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. You will have the opportunity to send a statement explaining why you disagree with our decision to deny your amendment request and we will share your statement whenever we disclose the information in the future.

4. Right to an accounting disclosures we have made
You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made (Information that we have released to those entities for which are deemed appropriate and for which you have given authorization. If you would like to receive an accounting, you may send us a letter requesting an accounting. Our agency must act on this request no later than 60 days after receipt of the request.

The accounting will not include several types of disclosures, including disclosures for treatment, payment, or health care operations. It will also not include disclosures made prior to February 1, 2013.
If you request an accounting more than once every twelve (12 months), we may charge you a fee to cover the costs of preparing the accounting.

5. Right to request restrictions on uses and disclosures
You have the right to request that we will limit the use and disclosures of health care information about you for treatment, payment, and health operations.

We are not required to agree to your request.

If we do agree to your request, we must follow your restrictions (except if the information is necessary for an emergency situation or unless it is a situation with mandates by State and Federal law). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

6. Right to request an alternative method of contact

You have the right to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternation method of contact, you must provide us with a request in writing.

YOU MAY FILE A COMPLAINT
ABOUT OUR PRIVACY PRACTICES

If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a complaint either with us of with the Federal government. We will not take any action against you or change our treatment of you in any way if you file a complaint.

To file a written complaint, you may bring your complaint to your clinician, his/her supervisor, the Executive Director or you may mail it to the following address:

ATTN: Executive Director, Safe Haven Child and Family

4822 Suite 202 Albemarle Rd.
Charlotte, North Carolina 28205

To file a complaint with the DHHS, you may send you complaint to the following address:

ATTN: Jim Jarrard, Acting Director
3001 Mail Service Center
Raleigh, NC 27699-3001

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- I acknowledge that I have been provided a copy of the Notice of Privacy Practices for Safe Haven Child and Family.

- I understand that the Notice of Privacy Practices discusses how my personal health care information may be used and/or disclosed, my rights with respect to health care information, and how and where I may file a privacy-related complaint.

- I may review a copy of the Notice in the main office of Safe Haven Child and Family

- I may review a copy of the Notice in the main office of Safe Haven Child and Family

- I understand that the terms of this Notice may be changed in the future, and theses changes will be posted in the main office of Safe Haven Child and Family I may also request a copy of the new Notice by contacting the Executive Director and/or designee at 704-763-9555.

_____ _____
Signature of Client Date Signed

Signature of Legally Responsible Person, If Required

Date Signed