

Sonthe Burge, Registered Dietitian & Licensed Nutritionist

Client Information

Client Name _____ Date _____

Name you prefer to be called _____ Date of Birth _____

Address _____

Home Phone _____ Cell Phone _____

At which number do you prefer to be contacted regarding appointments or billing questions?

Home **Cell** **Other** _____

May we leave a message on voice mail at this number? Yes No

May we leave a message with a person at this number? Yes No

Thank you for selecting Personal Relationships, Inc. for your counseling needs. We strive to provide the highest quality and most professional services for promoting your well being. If you ever have any questions or comments, please do not hesitate to contact our office at (205) 979-6822. Our phones are generally answered Monday-Friday 8am-5pm. If necessary, please leave a message and we will return your call as soon as possible.

Fees & Payments: Ms. Burge's fee is \$65 per 50 minute session. Personal Relationships, Inc. is a non-profit organization that depends on counseling fees and private donations to continue our ministry. Therefore, payment is expected at the time of your visit.

Cancellations & Missed Appointments: It is important that appointments be kept. If you must cancel your appointment, **please call 24 hours in advance to avoid a full charge.** This office does not double book appointments; therefore your appointment time is reserved for you. Missed appointments will be billed to you in full. Because of the nature of our schedule, clients that miss two appointments or repeatedly cancel appointments will be referred to another clinician's office.

Acknowledgement

Please read and initial all of the following statements (must be completed by parent/guardian if patient is under 18):

_____ I acknowledge that I have read and understand all of the PRI office policies and that my signature below indicates that I agree to abide by these policies.

_____ I have received a copy of the notice PRI privacy practices and I have read and understand my rights under HIPPA regarding my protected health information.

_____ I understand that I am responsible for all fees incurred at the time of my visit.

_____ I consent to the exchange of treatment information between Personal Relationships clinicians for the benefit of my therapy.

I certify that to the best of my knowledge, that all of the information provided in these documents is true and correct.

Printed Name of Patient or Guardian

Signature of Patient or Guardian

Today's Date

PERSONAL RELATIONSHIPS, INC.—NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your health information. "Protected Health Information" is information about you, including demographic information, that may identify you that relates to your past, present, or future physical or mental health condition or related health care services. We are also required to give you Notice about your privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This Notice takes effect 1/1/05, and will remain in effect until we replace it.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information at the end of the Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION: Uses and Disclosures of Protected Health Information are based upon your written consent. You will be asked by your therapist to sign an acknowledgment of receipt form. Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health care information may also be used and disclosed to pay your health care bills and to support the operation of this practice.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information as necessary to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may treat you when we have the necessary permission from you. Your protected health information may be provided to a physician to whom you have been referred to insure that the physician has the necessary information to diagnose and/or treat you. Additionally, your protected health information may be disclosed to another physician or health care provider (e.g. a specialist or laboratory) who becomes involved in your care, to a pharmacy as part of your treatment by your therapist, and may be used for research purposes.

Payment: Your protected health will be used as needed to obtain payment for your health care services. This may include certain activities that your health insurance company requires before it approves or pays for services we recommend for you such as; making a determination of eligibility or coverage for benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed, your protected health care information in order to support the business activities of your therapists' practice. These activities include, but are not limited to volunteer work, evaluating practitioner and provider performance, licensing or credentialing activities. (E.g. we may call you by name in the waiting room when your health care provider is ready to see you, or when contacting you to remind you of an appointment)

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time except to the extent that your therapist or the practice has taken action in reliance on the use or disclosure indicated in the authorization.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

We may use and disclose your protected health information in the following instances (emergencies, as required by law, or worker's compensation). You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object, then your therapist may, using professional judgment, determine whether the disclosure is in your best interest.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your therapist shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment.

Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and you will be notified, as required by law, of any such disclosures.

Worker's Compensation: Your protected health information may be disclosed as authorized to comply with worker's compensation laws and other similarly legally established programs

YOUR RIGHTS

Restriction: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment or payment of healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your therapist is not required to agree to a restriction that you may request. If your therapist believes it is in your best interest to permit use and disclosure of your protected health information, it will not be restricted. You may request a restriction by verbally noting to your therapist or in writing.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health care information for purposes, other than treatment, payment, healthcare operations and certain other activities that occurred after 1/1/2005. The right to this information is subject to certain exceptions, restrictions, and limitations.

Alternative Communication: We will accommodate reasonable requests. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Complaints: You may complain to us or to the Office of Civil Rights if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaints. We will not retaliate against you for filing a complaint.

Contact Person: Daniel G. Bowman, Ph.D., Executive Director, Personal Relationships, Inc.
Telephone: 205-979-6822 Fax: 205-979-6246
Address: 1310 Alford Avenue, Suite 201, Birmingham, AL 35226