Patient's Last Name	First	Middle	Date of Birth	

Street Address	City	State	Zip code

Name of Parent or Legal Guardian (if applicable)	Relationship to Patient	Emergency Contact Name & Phone Number

Email Address, if it's ok that I contact you this way	Cell Phone Number Ok to leave message?	Other Phone Number
	☐ Y ☐ N	
Please either fill out the following, or attach your insurance card instead	☐ I prefer to pay privately. I am not going to inform Dr. Klein that I have insurance because I wish not to use a third party payer. (skip sections below)	
Name of Primary Insurance Company	Policy Number	Group Number

Insurance Company Address (See back of card)	Insurance Company's Phone # (See back of card)

Name of Policy Holder (If not same as patient)	Policy Holder Date of Birth

Name of Psychiatrist:

I have read all of the following documents and I agree and consent to all policies. I consent that "Reliable MH Billing" company will bill my insurance and that I will receive either postage or email, at the addresses provided above, containing my statements or other relevant information.

Patient(s) or Legal Guardian's Signature Today's Date

Minor's Signature Today's Date

Please sign page 7 & 8

Dr Klein Psychological Services, Inc, Inc.
990 Highland Dr, 105A, Solana Beach CA 92075
Phone:760-889-0118, Fax: 858-925-8035, drklein@mdofficemail.com

OFFICE POLICIES AND INFORMED CONSENT:

This document is about our services and policies. If you sign this document, it will represent a contract between us. If you have not been given your own copy of this document, please request one. It is very important that you carefully and thoroughly read each section of this document before signing it.

Psychological Services

Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have significant and lasting benefits for people who go through it. 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.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Supervision of Children under Age 14

This policy was created with the safety and wellbeing of your child in mind. As a small practice, Dr Klein Psychological Services, Inc does not have the ability to provide supervision to your children. **Children under the age of 14 must be accompanied by an adult at all times when not in session.** While your child is in session, an adult must remain on premises at all times. It is your responsibility to monitor your children and be sure that they do not leave the waiting area.

Supervision of Persons Over Age 14

The above policy applies to all persons over the age of 14 who are unable to be left unattended due to mental or physical disability.

Child Psychological Services

Prior to beginning psychotherapy, psychological testing, or other psychological services with your child, it is important for you to understand my approach to child treatment and agree to some rules about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Patient-Therapist Agreement. Under HIPAA and the APA Ethics Code, I am legally and ethical responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is

necessary to refer your child to another mental health professional I will share that information with you. I will not share with you what your child has disclosed to me without your child's assent. I will tell you if your child does not attend sessions. By request, at the end of your child's treatment, I can provide you with a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you. **By signing this, you agree that you will not be notified of any information about your adolescent unless I believe he or she is at risk of being physically harmed.**

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $250 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

Professional Records

The laws and standards of my profession require that I keep treatment records. In most instances, you are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records they are often misinterpreted by laypersons. If you wish to review your records, I recommend that you review them in my presence or with another psychologist. Patients will be charged the applicable rate for professional time, (plus copy fees of 75 cents per page) when responding to information requests. As with most health care providers, Dr Klein Psychological Services, Inc makes increasing use of technology to enhance the quality of care provided. As technology evolves, more and more patient information is stored and transmitted electronically. Every effort is made to assure the security of our systems and the privacy of your data.

Meetings

I conduct an intake evaluation that lasts from 1 to 3 sessions. If we both agree on your treatment needs, then we will typically schedule one or two sessions per week at a time we agree on. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation. If you do not show or cancel with less than 48-hours' notice, then I reserve the right to terminate your treatment here and refer you to another clinician. Generally, services may be terminated when two unexcused late cancellations or no-shows occur within any six month period.

Translation:

Dr Klein Psychological Services, Inc does not provide translation services. You are responsible for providing a professional translator if needed.

Referrals and Termination of Services

Occasionally, I may refer you to another provider such as a health care specialist who is not pre-screened. It is your obligation to verify the credentials and quality of services of those you are referred to. Certain circumstances may require me to terminate or suspend the services that I provide to you. These include frequent missed sessions, delinquent billing, litigation, and safety concerns. In the event that I must discontinue providing services to you, I will notify you with advanced notice if possible. Upon request I will provide you with a list of alternative providers. You have the right to terminate your services at any time, with or without notice. If the patient is a child then I recommend that you allow at least two termination sessions for us to end our work together.

Insurance Reimbursement

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will submit forms required to help you receive the benefits to which you are entitled. ***Ultimately, you, and not your insurance company, are responsible for full payment of all fees***. It is important that you find out exactly what mental health services your insurance policy covers and whether preauthorization of services is required. If you have questions about your coverage, call your plan administrator.

Most insurance companies require that I provide them with your clinical diagnosis. Sometimes I must provide additional clinical information such as treatment plans or summaries. This information will become part of the insurance company files and may be stored electronically. Upon request, I will provide you with an accounting of any information I submit (reasonable costs may apply). Unless prohibited by contract, you may have the right to continue services without release of documents by paying for the services without insurance.

It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as 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 me to provide services to you once your benefits end.

I also use an insurance processing agency. They will have access to your insurance information and your diagnosis in order to process your claims.

Contacting Me

I am not on call and I am often not immediately available by telephone. While I am usually in my office weekdays between 9 AM and 5 PM, I will not answer the phone when I am in session. When I am unavailable, my telephone is answered by voice mail. I will make every effort to return your call within 72 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. You can also call 911 or the Access and Crisis Line at 1-888-724-7240.

Confidentiality

In general, the privacy of all communications between a patient and a psychologist is protected by law. I will only release information with your written permission. But there are a few exceptions. For example, if your services are covered by a third party such as Victims of Crime, Workers Compensation, or by Health Insurance, it may be necessary to disclose limited confidential information to those agencies as required by law or by contract, or as required for reimbursement of services rendered. In most legal proceedings, you may have the right to prevent me from providing any information about your treatment, but I cannot guarantee that. A court process may demand and require my records and I can claim privilege if you ask that I do, but a judge can order records to be released. There are also situations in which I am legally obligated to take action to protect others from harm, even when this requires that I reveal some information about a patient's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency. If I believe that a patient is seriously threatening severe bodily harm to another or to themselves, I am required 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, I may be obligated to seek hospitalization for him/her, and I may contact family members or others who can help provide protection. These situations rarely occur, but whenever possible I will discuss the issue with you before taking any action.

I must also report the following:

(1)Conduct involving matter depicting a minor engaged in obscene acts in violation of Section 311.2 (preparing, selling, or distributing obscene matter) or subdivision (a) of Section 311.4 (employment of minor to perform obscene acts).

(2) A person who knowingly promotes, aids, or assists, employs, uses, persuades, induces, or coerces a child, or a person responsible for a child's welfare, who knowingly permits or encourages a child to engage in, or assist others to engage in, prostitution or a live performance involving obscene sexual conduct, or to either pose or model alone or with others for purposes of preparing a film, photograph, negative, slide, drawing, painting, or other pictorial depiction, involving obscene sexual conduct. For the purpose of this section, "person responsible for a child's welfare" means a parent, guardian, foster parent, or a licensed administrator or employee of a public or private residential home, residential school, or other residential institution.

(3) A person who depicts a child in, or who knowingly develops, duplicates, prints, downloads, streams, accesses through any electronic or digital media, or exchanges, a film, photograph, videotape, video recording, negative, or slide in which a child is engaged in an act of obscene sexual conduct, except for those activities by law enforcement and prosecution agencies and other persons described in subdivisions (c) and (e) of Section 311.3.

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

Report Writing and other Production Deadlines

Dr Klein Psychological Services, Inc does not guarantee production deadlines and advises that you allot additional time when seeking out services that may be needed for a specific date. Test reports can require 4 weeks to be written and in some cases more time is required. Timelines are dependent on the complexity of the report as well as present market demands and other factors. Deadlines for report production cannot be guaranteed and it is strongly advised that you consider this factor prior to initiating any psychological testing services

Conjoint Therapy Confidentiality Limitations

If you are participating in marriage or family counseling, couples counseling, court-ordered counseling or court-ordered treatment workshops/groups or other forms of group psychotherapy: be certain to discuss the limits to confidentiality specific to your care. The nature of group counseling, marital counseling, family therapy, and other conjoint therapies involves significant limitations on confidentiality between the participants. During these forms of treatment, confidentiality is waived among the participants to the extent necessary to provide effective treatment.

Dr Klein Psychological Services, Inc obtains services from transcriptionists, billing services, practice reviewers, quality assurance consultants, certification/accreditation agencies, health insurers, accounting/legal providers and other professionals. Our business associates have access to clinical records only as necessary to perform their duties. All of our business associates are required to strictly protect and safeguard confidential information. I may occasionally find it helpful to consult other professionals about a case. During consultations, I do not reveal the identity of my patients. The consultant is also legally bound to keep all information confidential.

Your Rights Regarding Information In Your Medical Record

Right to Inspect and Copy; You are entitled to receive a copy of your medical record unless I believe that receiving that information would be emotionally damaging. Because these are professional records, they can be misinterpreted

and/or upsetting to untrained readers. If you wish to see your records or receive a copy of your records, I require written notice to that effect, and I would expect to discuss your request with you in person. If I deny you access to your records, you can request to speak with an independent colleague of mine about your request. Your request for independent review of your request should also be made in writing. If you are provided with a copy of your medical record information, I may charge a fee for any costs associated with that request. **Right to Amend;** If you believe that the information I have about you is incorrect or incomplete, you may ask me to amend that information. It is my practice to accept this sort of request in writing, and that any information you may wish to add to your record also be provided to me in written form. **Right to an Accounting of Disclosures;** You have the right to request an "Accounting Of Disclosures." This is a list of the disclosures I have made of medical record information. That information is listed on the *Authorization To Release Information*, and will be provided to you at your written request. **Right to Request Restrictions;** You have the right to privacy, and to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. As noted above, I will not release your confidential information without your written permission. Any restrictions to your *Authorization To Release Information* should be specified on the *Authorization*. **Right to Request Confidential Communications;** You have the right to request that I communicate with you only in certain ways. For example, you can ask that I not leave a telephone message for you, or that I only contact you at work or by mail.

Your Rights Regarding Information In Your Medical Record (continued)

Complaints Regarding Privacy Rights; If you believe your privacy rights have been violated, you may file a written complaint with me, or with an independent colleague of mine, or with the U.S. Department of Health and Human Services, 50 United Nations Plaza, Room 322, San Francisco, CA, 94102. You will not be penalized for filing a complaint.

Agreement to Arbitrate: It is understood that any dispute as to psychological malpractice, that is as to whether any psychological services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the psychologist and the psychologist's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including claims for loss of consortium, emotional distress or punitive damages. A demand for arbitration must be communicated in writing to all parties. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request.

Legal Advice Not Available

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. Although I am happy to discuss any concerns you have, I am not an attorney. At no time should any information that I provide you be construed as legal advice. If you require legal services, please consult a lawyer referral service recommended by your state's Bar Association.

Amendments, Reformation, Severability

This policy constitutes a signed contract between us. Your signature below indicates that you understand and agree to abide by these policies in exchange for participation in services with our clinic. If any court should determine the policies herein to be excessive in duration or scope or unreasonable or unenforceable under the laws of that state, it is the intention of both parties that such restriction may be modified or amended by court to render it enforceable to the maximum extent permitted by the laws of that state. Should reformation not be possible, and any court determine that the any portion of this contract is invalid or unenforceable the remainder of the contract shall not thereby be affected and shall be given full effect without regard to the invalid

portions. This policy may not be amended or altered by oral agreement. Verbal agreements to alter this contract will not be binding. Any modifications, alterations or amendments to this policy must be made under the written consent of Dr. Klein.

I have read this document, and I understand and agree to its terms. I understand that I, and not my insurance company, am responsible for payment of fees. I authorize payment of benefits from my insurance to be paid directly to Dr Klein Psychological Services, Inc. I authorize Dr Klein Psychological Services, Inc. to release to my insurance company any information necessary for processing insurance claims, and that he is not responsible for the insurance companies handling of my confidential information. I have received and agree with the attached HIPAA notice.

_____ _____

Signature of Patient or Patient's Representative | Today's Date

FINANCES

Standard Fees:

- **Initial Assessment: $140**
- **Ongoing Treatment, per hour: $140**
- **Psychological Testing/Evaluation, per hour: $140**
- **Couples Treatment, per hour: $140**

- **Or,**

- **Fees required by your insurance plan including deductibles/copays**

- I understand that my fee is subject to periodic review, particularly if my financial situation changes and I am paying a reduced fee. I agree to pay for services at the time they are provided, or as mutually agreed upon. If I am utilizing my health insurance to pay for these services, I hereby assign any payments from my health insurance provider to Dr Klein Psychological Services, Inc. I agree to be responsible for any charges not covered by my health insurance, including deductibles. It is my responsibility to understand the details of my own coverage prior to coming in.

- I understand that my health insurance cannot be billed for missed appointments. I agree to pay my full session fee for appointments missed without providing **2 business days notice**. Some medical emergencies excepted.

- General sickness or some stressful matters (ex, car trouble, scheduling problems, and more) are not considered emergencies. I agree to pay my session fee for appointments missed for reasons that are not emergency medical matters.

- If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I 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 I release is the patients name and identifying information, a list of the services provided, and the amount due.

- I charge my full fee/hr for other professional services such as report writing, telephone conversations longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, etc. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $250 per hour (8 hour minimum) plus all costs for preparation and attendance at any legal proceeding. Travel and off-site attendance for formal hearings including PPT/IEP meetings, adjudication hearings, etc. are billed at $250 per hour with an 8 hour minimum.

I have read this financial policy and agree to all terms and conditions.

_____ _____

Signature of Patient or Patient's Representative Today's Date

Dr Klein Psychological Services, Inc, Inc.
990 Highland Dr, 105A, Solana Beach CA 92075
Phone:760-889-0118, Fax: 858-925-8035, drklein@mdofficemail.com

HIPAA NOTICE OF PRIVACY PRACTICES

I. 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.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in my office.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.

I may use and disclose your PHI without your consent for the following reasons:

1. For treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.
2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.
3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.
4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent.

I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.** Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**
3. **If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**
4. **If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations**, such as the Privacy Rule that requires this Notice.
5. **To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds).
6. **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**
7. **If disclosure is mandated by the California Child Abuse and Neglect Reporting law.** For example, if I have a reasonable suspicion of child abuse or neglect.
8. **If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law.** For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. **If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.**
10. **For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. **For health oversight activities.** Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. **For specific government functions.** Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
14. **For Workers' Compensation purposes.** I may provide PHI in order to comply with Workers' Compensation laws.
15. **Appointment reminders and health related benefits or services.** Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer**.**
16. **If an arbitrator or arbitration panel compels disclosure,** when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. **If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.** Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
18. **If disclosure is otherwise specifically required by law.**

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.
If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

If you allow and or prefer email or electronic communication you understand that such methods are not entiterely secure. Dr Klein Psychological Services, inc does its best to safeguard ePHI in a manner that conforms to HIPAA standards, but cannot guarantee electronic security. You agree to absolve the corporation and any of it's providers for any breach of data.

D. The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

F. The Right to Get This Notice by Email You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. I will take no retaliation.

VII. EFFECTIVE DATE OF THIS NOIICE

This notice went into effect on 6/1/13