Robin M. Gilmore, LCSW, LLC

Identifying Information

Client's Name: Parent's Name:	
Date Completed:	

Address:				Phone:	
Email:				DOB:	
Employer or School:		Address and Phone Number:		Sex:	
Race:		Referral Source:		Phone:	
Primary Care Physician:		Address:		Phone:	

Legal Guardian and/or Parent telephone address (*if different from client*):	
Primary Language:	

Collateral/Emergency Contacts			
Name	Relationship to Client	Phone	Email

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Developmental History for Minors

Child's Name:_____DOB:_____Age:_____

Person Completing this form: _____Relationship to Child:_____

Mother's Name:_____DOB:_____Age:_____

Father's Name: _____DOB:_____ Age:_____

Child's custodian/guardian is: _____

Other adult family members living in the house_____

Child Development:
Pregnancy and delivery:
Prenatal medical illnesses and health care:_____

Premature? Yes_____ No_____ Weight and height at birth:_____

Health
Please list childhood illnesses, hospitalizations, medications, allergies, important accidents and injuries, surgeries, head injuries, convulsion/seizures, and other medical conditions.

Condition	Age	Who/Where treated?	Consequences?

Residences
Homes

Location	Dates	with Whom	Reason for moving

Residential placements, institutional placements, or foster care

Program name or location	Dates	Reason for placement	Concerns?

Schools

Name/District	Grade	Age	Teacher

May I call and discuss your child with the current teacher? Yes_____ No_____ If Yes, please complete a release of information (ROI) for that teacher (I will supply the ROI)

Preferences

Please list any hobbies, sports, recreational, musical, or TV interests:

_____
_____
_____

Checklist of Characteristics for Minors

Please list any of the following concerns and positive traits that describe your child. Feel free to add any others at the end which may not appear in this list.

- ☐ Abuse–physical, sexual, emotional, cruelty to animals
- ☐ Affectionate
- ☐ Alcohol use
- ☐ Anger, aggressive, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Cheats
- ☐ Concern for others
- ☐ Conflict with parents
- ☐ Confusion
- ☐ Compulsions
- ☐ Cries easily, feelings at easily hurt
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Developmental delays
- ☐ Drug use–prescription medications, over-the-counter medications, street drugs
- ☐ Eating problems–overeating, undereating, appetite, vomiting (see also “Weight and diet issues”)
- ☐ Extracurricular activities interfere with academics
- ☐ Failure in school
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Fire setting
- ☐ Friendly, outgoing, social
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses
- ☐ Guilt
- ☐ Headaches, other kinds of pains
- ☐ Health, illness, medical concerns, physical problems
- ☐ Housework/chores–quality, schedules, sharing duties
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking
- ☐ Learning disability
- ☐ Loneliness

- ☐ Low frustration tolerance
- ☐ Memory problems
- ☐ Mood swings
- ☐ Motivation
- ☐ Mail biting
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Pain, chronic
- ☐ Panic or anxiety attacks
- ☐ Relationships (friends, family)
- ☐ Responsible
- ☐ Runs away
- ☐ School problems
- ☐ Sad, unhappy
- ☐ Self-harming behaviors-biting, hitting, cutting self
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunctions, conflicts, desire differences
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep Problems-too much, too little, insomnia, nightmares
- ☐ Smoking and tobacco use
- ☐ Spiritual, religious, moral, ethical issues
- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness, distrust
- ☐ Suicidal thoughts or attempts
- ☐ Tics-involuntary rapid movements, noises, or word productions
- ☐ Thought disorganization and confusion
- ☐ Teased or teases others
- ☐ Truancy
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating
- ☐ Other concerns or issues:_____

Please look back over the concerns you have checked off and choose the one(s) that you most want help with. It is/they are:

_____

CONSENT FOR TREATMENT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and make note of any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

COUNSELING SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. 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 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.

MEETINGS

I normally conduct an initial evaluation that will last 1.5 hours, if time allows. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy begins, I typically schedule one 45-minute session 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' (two business days) advance notice of cancellation. If it is possible, I will try to find another time to reschedule the appointment that week, in accordance with my schedule availability. If another appointment cannot be scheduled during that week, you will be responsible for the full appointment fee. Please be advised that insurance companies do NOT reimburse for missed appointments; therefore you will be responsible for the full session fee.

PROFESSIONAL FEES

The fee for my initial assessment is $300, since it is a 90-minute session. The fee for an individual, family, or couples 45-minute therapy session is $150. In addition to weekly appointments, I charge $150 per hour for other professional services you may need, though I will break down the hourly cost into 15- minute increments if I work for periods of less than one hour. Other services can include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other

service you may request of me. Please be advised that I do not currently provide phone sessions. 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 $165 per hour for preparation and attendance at any legal proceeding, including preparation of any documentation needed for a court proceeding or legal issue.]

PLEASE SEE ATTACHED FINANCIAL FEE POLICY AND AGREEMENT FOR ADDITIONAL DETAIL

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will provide you with a monthly statement of fees paid in order to help you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. I do not deal directly with any insurance companies.

CONTACTING ME

I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail that I monitor daily (excluding weekends). I will make every effort to return your call on the same day you make it, 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 cannot reach me in an emergency, please utilize the crisis numbers provided you at your initial visit, call your primary care physician, your psychiatrist if applicable, or go to your nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. 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 can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Please note that there is a fee associated with obtaining a copy of your medical record, which is a $0.25 copy fee per page; there is also a labor fee, which is based on a prorated scale of my hourly fee.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a therapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

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

There are also some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child [or 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 threatening serious bodily harm to another, 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 or to contact family members or others who can help provide protection. If I feel that a client is in eminent danger and is unwilling to cooperate with my assistance, in some instances I may be required to ask for legal assistance to ensure safety.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other licensed professionals about a case. During a consultation, I do not reveal the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

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

_____

(Signature) (Printed Name) (Date)

_____

(Signature) (Printed Name) (Date)

THERAPY AGREEMENT FOR MINORS

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some guidelines about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Client-Therapist Agreement. Under HIPAA, I am legally and ethically responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

Therapy is most effective when a trusting relationship exists between the therapist and the client. 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 detailed treatment records; apart from diagnostic information, treatment, plans and treatment summaries.

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 with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. At the end of your child's treatment, if requested, I will 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.

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 $150 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

It is important for you to understand that I am a mandated reporter of suspected child abuse. Should you or your child disclose abuse to me, at any time, I am required, by law, to report that information to child protection services.

Abbreviated Contract Draft

- You are waiving your right to access to your child's detailed treatment records; apart from diagnostic information, treatment plans and treatment summaries.
- I will inform you if your child does not attend the treatment sessions.
- At the end of treatment, if requested, I will provide you with a summary that includes a general description of goals, progress made, and potential areas that may require intervention in the future.
- You agree that my role is limited to providing treatment and that you will not involve me in any legal dispute, especially a dispute concerning custody or custody arrangement (visitation, etc).
- 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.
- If there is a court appointed evaluator, and if appropriate releases are signed and a court order I provided, I will provide general information about the child which will not include recommendations concerning custody or custody arrangements.
- If, for any reason, I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate $150 for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.
- It is important for you to understand that I am a mandated reported of suspected child abuse. Should you or your child disclose abuse to me, at any time, I am required, by law, to report that information to child protection services.

_____

Signature of Client Date

Signature of Parent Date

Signature of Parent Date

FINANCIAL POLICY & AGREEMENT

The following is a clarification of the financial /fee policies and agreement. I ask that you read this document and sign your name (s) indicating that you have read, and agree to the following information. Should you have any questions please feel free to discuss them with me.

Payment is due at the time of service. I accept cash and checks.

Your fee applies to each forty-five-minute individual and/or family session.

Checks returned due to insufficient funds will incur a charge. This fee replicates the fee the bank sets forth for returned checks, plus the amount the check was written for.

It is your responsibility to become familiar with and understand your health insurance benefits, including behavioral health insurance benefits, prior to the first session scheduled for you, your child or your family. I do not deal directly with any insurance companies.

As the time scheduled for your appointment is reserved for you, I ask that you give 48 hours' notice (two business days), by phone or email, if it is necessary to cancel an appointment. If notice is given in less than 48 hours, you will be charged the full fee for that session ($145-$290). Rescheduling of cancelled appointments may be made within the same week of the cancelled session, and only as my schedule allows. **Further, insurance companies do not reimburse for cancelled sessions so you will be charged the full rate for that session.**

If you terminate therapy with an outstanding balance of fees you will still be responsible for paying said fees, and if necessary all costs of collection, including attorney's fees.

From time to time the therapy fees may change. I will notify you at least 60 days in advance if there is a change in the fee schedule.

I, and or we, have read, understand, and agree to the above policies.

_____

(Signature) (Printed Name) (Date)

_____

(Signature) (Printed Name) (Date)

MY PRIVATE PRACTICE SOCIAL MEDICA POLICY

This document outlines my office policies related to use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet. If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

FRIENDING
I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk about it.

INTERACTING
Please do not use messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.
If you need to contact me between sessions, the best way to do so is by phone or email directly at robingilmorelcswllc@gmail.com.

USE OF SEARCH ENGINES
It is NOT a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions *may* be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there *might* be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

BUSINESS REVIEW SITES
You may find my psychology practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client. It is unethical for social workers to solicit testimonials. Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it.

If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like. Confidentiality means that I cannot tell people that you are my client and my Ethics Code prohibits me from requesting testimonials. But you are more than welcome to tell anyone.

I, and or we, have read, understand, and agree to the above social media policies.

(Signature) (Printed Name) (Date)

(Signature) (Printed Name) (Date)

HIPAA NOTICE OF PRIVACY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on my website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

For Payment. I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. I may use or disclose, as needed, your PHI in order to support my business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, I must disclose your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is my practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the NASW Code of Ethics and HIPAA.

Child Abuse or Neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. I may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. I may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. I may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. I will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. I may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. I may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. I may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, I may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. I may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Verbal Permission. I may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to Robin M. Gilmore, LCSW, LLC.

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstance, to inspect and copy PHI that is maintained in a "designated record set:. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. I may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with me. I may prepare a rebuttal to your statement and will provide you with a copy.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests. I may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. I will not ask you for an explanation of why you are making the request.
- **Breach Notification**. If there is a breach of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice**. You have the right to a copy of this notice.

COMPLAINTS

Robin M. Gilmore, LCSW, LLC

If you believe I have violated your privacy rights, you have the right to file a complaint in writing to Robin M. Gilmore, LCSW, LLC or with the Secretary of Health and Human Services at 200 Independence Avenue, S. W. Washington, D.C. 20201 or by calling (202) 619-0257. **I will not retaliate against you for filing a complaint.**

NATIONAL ASSOCIATION OF SOCIAL WORKERS, POPOVITS & ROBINSON, P. C. 2013

The effective date of this Notice is September 2013.

I, and or we, have read, understand, and agree to the above HIPPA Notice of privacy policies.

(Signature) (Printed Name) (Date)

(Signature) (Printed Name) (Date)

Robin M. Gilmore, LCSW, LLC

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____

DOB:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Robin M. Gilmore, LCSW, LLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Robin M. Gilmore at 571-305-2456 or robingilmorelcswllc@gmail.com.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian, or Personal Representative Date

_____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

____Patient/Client Refuses to Acknowledge Receipt:

_____

Signature of Staff Member Date