CATHERINE COURSON, LCSW
1169 EASTERN PARKWAY, STE. 3438
LOUISVILLE, KY 40217
cathycourson@gmail.com
502-473-7028

Thanks for your help in making your first session a productive one. Please note that if you are not able to complete the information on the following forms we will do them together in our first session.

FOR YOUR FIRST SESSION, YOU WILL NEED:

1. A copy of your insurance card and driver's license.
2. If using EAP, Employee Assistance Program benefits, the company's name that manages you benefits _____, their phone # _____ and your authorization # _____.
3. The client's social security.
4. The social security number and date of birth of the insurance policyholder.
5. Please call your insurance for verification of your mental health benefits, co-pay, and deductible. You will also need to ask them if you need an authorization number to access services. Authorization # if needed: _____
6. You will be responsible for the deductible portion and the co-pay for your session.
7. Please pay your co-pay at each session.

THINGS TO REMEMBER:

1. You are accountable for any session not authorized by your insurance company.
2. There is a missed appointment fee, and a late cancellation fee. The late cancellation fee of $50.00 is charged if I am not notified within 24 hours. This fee is not covered by insurance.
3. If there is a problem with making the payment, the therapist will give you an envelope for you to mail in the payment before your next session, or you can call with a credit card number before the next session. These arrangements should be made before the session.
4. Routines calls, such as rescheduling, are returned between 9:00 am and 5:00 pm during the week. The answering service will note the time called.
5. **I cannot do FMLA forms until I have seen you three times. The FMLA forms are not covered by insurance so that would require a separate fee of fifty dollars. IF you are an EAP client, I cannot release any information directly to your employer.**
6. **If this is a custody issue, and you hope I will be able to speak to your parenting skills, you are advised to seek counseling elsewhere.**
7. **Any depositions, court appearances, and time spent preparing to attend court, will be billed to you at an hourly rate of $150.00 dollars. I am not considered an expert witness and cannot promise the outcome that you might desire. I will, however, go over your notes with you, and my clinical recommendations. Please discuss the notes and recommendations with me before signing a release for your attorneys to get your clinical information.**

_____
CLIENT/REPRESENTATIVE SIGNATURE AND DATE

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What to expect during treatment:

1. We will review your demographic information, and all of the information from the enclosed forms.
2. We will determine the goals of treatment.
3. You will have the opportunity to ask questions relative to your treatment.
4. While in treatment you will be asked to do homework to speed your therapy along. I might ask you to read a book, journal, see your family doctor for a physical, attend AA, NA, ALON, ACOA, gamblers anonymous, overeaters anonymous, depression anonymous, or other tasks. These tasks are necessary to be successful in your treatment.
5. Only a portion of your treatment takes place in your sessions. Reading assignments and assigned activities between the sessions contribute to your treatment.
6. When dealing with traumas it sometimes gets worse before it gets better.

Please read and sign the next paragraph.

Emergencies are situations that could result in danger to self or others. Please go to the nearest emergency room should you experience an emergency or call 911.

Urgent calls are billable calls and are returned by me, or someone covering my calls. Please call the answering service and indicate that your call is urgent.

(502) 473-7028

If for some reason you can't reach me or I don't return your call within an hour and you need to talk to someone call the crisis and information line or go to your nearest emergency room.

Suicide Prevention	1-800-273-TALK

_____

CLIENT **DATE**

_____

CLIENT/REPRESENTATIVE SIGNATURE AND DATE

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502-473-7028

CLEINT DEMOGRAPHIC INFORMATION

FIRST NAME: _____ MI: _____

LAST NAME: _____

ADDRESS: _____

SUITE: _____

CITY: _____ STATE: _____

ZIP CODE: _____

EMAIL ADDRESS: _____

HOME PHONE: _____

WORK PHONE: _____

MOBILE PHONE: _____

PREFERRED PHONE NUMBER TO CALL: _____

FAX: _____

SOCIAL SECURITY: _____BIRTH DATE: _____

GENDER: _____

RELATIONSHIP STATUS: MARRIED ____ SINGLE _____
PARTNERED _____

EMPLOYMENT: NONE: _____

EMPLOYED: _____

DISABLED/UNEMPLOYED: _____

STUDENT: PART-TIME_____ FULLTIME: _____

PRIMARY INSURANCE: _____

INSURANCE ID: _____

GROUP NUMBER: _____

POLICY HOLDER DEMOGRAPHIC INFORMATION:
FIRST NAME: _____ MI: _____

_____
CLIENT/REPRESENTATIVE SIGNATURE AND DATE

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LOUISVILLE, KY 40217
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502-473-7028

LAST NAME: _____

ADDRESS: _____

SUITE: _____

CITY: _____ STATE: _____

ZIP CODE: _____

EMAIL ADDRESS: _____

HOME PHONE: _____

WORK PHONE: _____

MOBILE PHONE: _____

PREFERRED PHONE NUMBER TO CALL: _____

FAX: _____

SOCIAL SECURITY: _____BIRTH DATE: _____

GENDER: _____

RELATIONSHIP STATUS: MARRIED ____ SINGLE _____
PARTNERED _____

EMPLOYMENT: NONE: _____

EMPLOYED: _____

DISABLED/UNEMPLOYED: _____

STUDENT: PART-TIME_____ FULLTIME: _____

PRIMARY INSURANCE: _____

INSURANCE ID: _____

GROUP NUMBER: _____

_____
CLIENT/REPRESENTATIVE SIGNATURE AND DATE

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IF THERE IS A SECONDARY INSURANCE POLICY, YOU MUST DISCLOSE THIS AND BRING THAT CARD TO THE SESSION. PLEASE COMPLETE THE SAME INFORMATION FOR THE SECONDARY POLICY BELOW.

FIRST NAME: _____ MI: _____

LAST NAME: _____

ADDRESS: _____

SUITE: _____

CITY: _____ STATE: _____

ZIP CODE: _____

EMAIL ADDRESS: _____

HOME PHONE: _____

WORK PHONE: _____

MOBILE PHONE: _____

PREFERRED PHONE NUMBER TO CALL: _____

FAX: _____

SOCIAL SECURITY: _____BIRTH DATE: _____

GENDER: _____

RELATIONSHIP STATUS: MARRIED ____ SINGLE _____
PARTNERED _____

EMPLOYMENT: NONE: _____

EMPLOYED: _____

DISABLED/UNEMPLOYED: _____

STUDENT: PART-TIME_____ FULLTIME: _____

PRIMARY INSURANCE: _____

INSURANCE ID: _____

GROUP NUMBER: _____

_____

CLIENT/REPRESENTATIVE SIGNATURE AND DATE

CATHERINE COURSON, LCSW
1169 EASTERN PARKWAY, STE. 3438
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I certify that I, and/or my dependent(s), have insurance coverage with

_____

and assign directly to Catherine Courson, LCSW all insurance benefits, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named Therapist may use my health care information and may disclose such information to the above-named Insurance co. and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Authorization for Electronic Communication

As a convenience to me, I hereby request that Catherine Courson, LCSW communicate with me regarding my treatment via electronic communications (e-mail or text message). I understand that this means Catherine Courson, LCSW will transmit my protected health information such as information about my appointments, diagnosis, medications, progress and other individually identifiable information about my treatment to me via electronic communications.

I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, Catherine Courson, LCSW shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by Catherine Courson, LCSW to me.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize Catherine Courson, LCSW to communicate electronically with me, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications from Catherine Courson, LCSW, I may revoke this authorization by providing written notice to Catherine Courson, LCSW at 1169 Eastern Parkway, Ste. 411, Louisville, Ky. 40217 or fax at 502-454-0666.

I agree that Catherine Courson, LCSW may communicate with me electronically unless and until I revoke this authorization by submitting notice to Catherine Courson, LCSW in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

_____
CLIENT/REPRESENTATIVE SIGNATURE AND DATE

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I hereby authorize the transmission of my protected health information electronically as described above.
Patient Name _____ Date: _____

YOUR AGE: _____ REFERRAL SOURCE: _____

PRESENTING PROBLEM/PROBLEMS: _____

_____

_____

WHAT SYMPTOMS ARE YOU EXPERIENCING, THE SEVERITY AND FOR HOW LONG?

CHANGE IN APPETITE: Increase Decrease Other (*Explain*)
_____

CHANGE IN WEIGHT: Increase Decrease Other (*Explain*)
_____

CHANGE IN SLEEP: Increase Decrease Other (*Explain*)
_____

CHANGE IN ENERGY: Increase Decrease Other (*Explain*)
_____

CHANGE IN MOOD: Increase Decrease Other (*Explain*)
_____

CIRCLE ANY THAT APPLY:

SUBSTANCE ABUSE PHYSICAL ABUSE SEXUAL ABUSE FAMILY VIOLENCE FEAR
HOPELESSNESS HELPLESSNESS PANIC ATTACKS LOW SELF-ESTEEM SHY
WORTHLESSNESS ISOLATING SELF DEPRESSION ANXIETY
GRIEF
SELF-FOCUSED IRRITABILITY SEXUAL PROBLEMS SHAME
CRYING
WITHDRAWAL FREQUENT CRYING WORRYING GUILT
ANGER
FATIGUE LOSS OF TIME SUICIDAL THOUGHTS ONLY SUICIDAL INTENT
HOMICIDAL THOUGHTS ONLY HOMICIDAL INTENT

EXPLAIN ANY ITEMS THAT YOU CIRCLED FROM PAGE 7: _____

_____

_____

_____

PREVIOUS TREATMENT:

_____

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Former Therapist_____ Date of last counseling visit:_____

Dates of any inpatient hospitalizations:_____

_____
Dates of previous outpatient counseling and counselor:

_____

_____

_____

FAMILY FUNCTIONING: (FAMILY COMPOSITION, WHO LIVES AT HOME, SOCIAL FUNCTIONING, INTIMATE RELATIONSHIPS)

_____

_____

_____

_____

SOCIAL FUNCTIONING: (SUPPORT SYSTEM, AFTER WORK/SCHOOL ACTIVITIES:)

_____

_____

EDUCATIONAL/WORK HISTORY: (SCHOOL GRADES, LEARNING PROBLEMS, PART OF AN LD PROGRAM, PREVIOUS SERVICES// EMPLOYMENT ISSUES AND ARE YOU CURRENTLY SEEKING SHORT TERM OR LONG TERM DISABILITY?):

_____

_____

_____

PSYCHIATRIC HISTORY OF FAMILY TO INCLUDE DRUG OR ALCOHOL ABUSE OR DEPENDENCY:

_____

_____

TRAUMA HISTORY:

_____

_____
CLIENT/REPRESENTATIVE SIGNATURE AND DATE

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LEGAL ISSUES (PAST AND CURRENTLY)

QUESTIONS IF CLIENT IS A CHILD:

1. Are you the legal guardian with the authority to bring the child to treatment?
   Circle one: Yes or No.
   If you are a single parent I will need to see court custody papers.
2. **Developmental History** (milestones met early, late, normal):
3. **Perinatal History** (details of labor/delivery):
4. **Prenatal History** (medical problems during pregnancy, mother's use of medications):
5. **Grade and school attending:**
6. **Childhood traumas:**

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MEDICAL INFORMATION:

Physician's Name_____ Date of last visit_____

Please circle answer for each:

Yes No **Heart trouble/disease**
Yes No **Heart murmur**
Yes No **Irregular heartbeat**
Yes No **Angina/chest pain disorder**
Yes No **Sickle cell disorder**
Yes No **Hemophilia**
Yes No **Blood transfusion**
Yes No **Tuberculosis (TB)**
Yes No **Heart attack/failure**
Yes No **Stroke**
Yes No **Congenital heart disorder**
Yes No **Mitral valve prolapse**
Yes No **Rheumatic fever**
Yes No **Artificial heart valve**
Yes No **High blood pressure**
Yes No **High cholesterol**
Yes No **Pacemaker**
Yes No **Asthma**
Yes No **Hepatitis type_____**
Yes No **HIV/AIDS**
Yes No **Anemia**
Yes No **Stomach problems**
Yes No **Drug addiction**
Yes No **Alcohol addiction**
Yes No **Fainting or dizziness**
Yes No **Headaches/migraines**
Yes No **Cortisone treatments**
Yes No **Liver problems**
Yes No **Kidney problems**
Yes No **Diabetes type_____**
Yes No **Cancer/chemotherapy**
Yes No **Radiation treatment**
Yes No **Skin grafts**
Yes No **Back/neck problems**
Yes No **Emphysema**
Yes No **Nervousness**

_____
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Yes No **Arthritis/rheumatism** Yes No **Psychiatric care**
Yes No **Artificial joint replacement** Yes No **Seizure disorder**
***date of surgery_____** Yes No **Alzheimer's disease**
Yes No **Blood**

CURRENT MEDICATIONS:

_____
_____
_____

ALLERGIES TO MEDICINES, MATERIALS, OR FOOD:

_____
_____
_____
_____

CONSENT: I, the undersigned, a client or parent/guardian of a client, do hereby voluntarily consent and authorize Catherine Courson, L.C.S.W., B.C.D., to administer psychotherapy.

I am aware that the practice of psychotherapy is not an exact science and I acknowledge that no guarantees have been made to me as to the result of evaluation and treatment.

I understand that Catherine Courson, L.C.S.W., B.C.D., practices under the ethical guidelines set forth by the National Association of Social Workers. I further understand that she will make the appropriate referral for me if I have a need that she is unable to address.

_____ 11
CLIENT/REPRESENTATIVE SIGNATURE AND DATE

CATHERINE COURSON, LCSW
1169 EASTERN PARKWAY, STE. 3438
LOUISVILLE, KY 40217
cathycourson@gmail.com
502-473-7028

⇒_____ _____/_____/_____
Client or Responsible Party Signature Date

FINANCIAL AGREEMENT: Counseling fees are $125 for the first session and $100 for each additional 50-minute session. Co-pays are due prior to each session. Missed appointments or appointments cancelled without 24 hours notice will result in a $50 fee. There is a $25 returned check fee.
I understand and agree that any and all charges not covered by my insurance carrier(s) will be my responsibility and that I will make every effort to forward payment on all outstanding charges to my account in a timely manner. I further understand that not doing so may result in my delinquent account being turned over to a collection agency for further action.
I understand and agree to the above fees and responsibilities and will notify my therapist of any change in my insurance coverage.

⇒_____ _____/_____/_____
Client or Responsible Party Signature Date

UNDERSTANDING: I understand that Parkway Psychotherapy Associates, Inc. is a leasing agent to therapists who need office space and related services for the operation of their own individual private practice of psychotherapy. Under no circumstances is it to be misconstrued that any lessee nor Parkway Psychotherapy Associates, Inc. itself are a partner or an associate in the practice of psychotherapy with each other or are responsible for each other's conduct. Each lessee of office space is solely responsible for their own private practice of psychotherapy and conduct, including but not limited to providing malpractice insurance, scheduling, billing and record keeping.

By my signature below, I hereby agree to assure the confidentiality of information received from others or obtain from my own observation regarding clients, former clients, or persons whose treatment has been sought at the facilities of Parkway Psychotherapy Associates, Inc.

⇒_____
_____/_____/_____
Client or Responsible Party Signature
Date

CLIENT/REPRESENTATIVE SIGNATURE AND DATE

CATHERINE COURSON, LCSW
1169 EASTERN PARKWAY, STE. 3438
LOUISVILLE, KY 40217
cathycourson@gmail.com
502-473-7028

MANDATORY RELEASE OF INFORMATION: The undersigned acknowledges that Catherine A. Courson, L.C.S.W., B.C.D., is obligated by Kentucky law and by her professional regulating agency to report to the appropriate authorities any information obtained regarding the following:

- Incidents of abuse or neglect upon a child, either new or old, who is currently 16 years of age or under, that has never been reported to The Cabinet For Human Services, Child Protective Services. This will result in a mandatory investigation by a social worker within 72 hours. If there is a finding of abuse, there is mandatory involvement by the Court system and a caseworker from The Cabinet for Human Resources. KRS620.030
- Current incidents of abuse upon an adult, either by a spouse or another person, that has never been reported to The Cabinet For Human Resources, Adult Protective Services. This will result with a mandatory contact by a social worker inquiring whether you would like their services or whether you wish to decline their services. This can be done at the time of disclosure at the office. KRS209.030
- Any specific threats to cause bodily harm to any identified individual(s) including oneself, where there is a plan, available methods and the client refuses to take appropriate actions to not follow through with the threat. This will result in a mandatory contact with the Police Department. In the case of suicidal behavior, the next of kin will be notified and a mental inquest warrant may be issued, resulting in a 72-hour hold in an inpatient setting for stabilization. In the case of homicidal behavior the intended victim will also be notified. These actions may result in criminal charges.
- Any breach of a Court order, specifically a restraining order, no-contact order or protective order, must be reported to the Courts.
- If ordered to treatment by Court, Probation, Parole or The Department for Human Services, failure to cooperate with the treatment plan must be reported.

(Sign once for each person present in the session).

⇒SIGNATURE_____

DATE_____

⇒SIGNATURE_____

DATE_____

⇒SIGNATURE_____

DATE_____

_____
CLIENT/REPRESENTATIVE SIGNATURE AND DATE

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1169 EASTERN PARKWAY, STE. 3438
LOUISVILLE, KY 40217
cathycourson@gmail.com
502-473-7028

MEDICARE AUTHORIZATION: I am responsible for my coinsurance and deductible at the time of service. I direct the payment from Medicare be paid directly to Catherine A. Courson, L.C.S.W., and B.C.D. I authorize her to release any and all medical information about me to the Health Care Financing Administration and its agents to determine these benefits or the benefits payable for her services. In the case of insurance my signature also authorizes release of information to the insurer or agency I have listed. The therapist agrees to accept the charge as set by Medicare as the full charge for the services.

⇒_____ _____ / _____ / _____
Client or Representative Signature DATE

LIMITED CREDIT CARD AUTHORIZATION: I authorize Catherine Courson, L.C.S.W., to keep my signature on file and to charge my credit card for any fees due under the Financial Agreement and not paid by my insurance carrier,

CLIENT Name (Print)
_____

Name as It Appears on CREDIT CARD (Print)
_____
Credit Card Number:

Expiration Date Month / Year: Validation

Code:

Three numbers at right on back of card

Cardholder Signature_____
Date_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES. I affirm that Catherine A.

_____
CLIENT/REPRESENTATIVE SIGNATURE AND DATE

CATHERINE COURSON, LCSW
1169 EASTERN PARKWAY, STE. 3438
LOUISVILLE, KY 40217
cathycourson@gmail.com
502-473-7028

Courson, L.C.S.W., B.C.D., or her staff gave me a copy of the Notice of Privacy Practices effective.
(Please take the papers labeled HIPPA **PRIVACY NOTICE** with you.)

_____ ____ / ____ / ____
Client or Representative Signature Date

HIPPA PRIVACY NOTICE: *PLEASE TAKE THESE HIPPA PAGES AND MAKE SURE YOU HAVE SIGNED THAT YOU RECEIVED THEM ON THE PREVIOUS:*

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.

Note that I reserve the right to change this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will 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 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

CLIENT/REPRESENTATIVE SIGNATURE AND DATE

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 the patient compels disclosure or the patient's representative pursuant 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.
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 Kentucky 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 Kentucky 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. I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that may be of interest to you.
18. 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.
19. If disclosure is otherwise specifically required by law.

C. Certain Uses and Disclosures require you to have the opportunity to object. 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 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?

CLIENT/REPRESENTATIVE SIGNATURE AND DATE

CATHERINE COURSON, LCSW
1169 EASTERN PARKWAY, STE. 3438
LOUISVILLE, KY 40217
cathycourson@gmail.com
502-473-7028

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.

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 E-mail. You have the right to request a paper copy of it, as well.

1. 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. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES **If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me.**

CLIENT/REPRESENTATIVE SIGNATURE AND DATE