ANGELA M. PFEIFFER, Ph.D.
Clinical Psychologist
12946 Dairy Ashford, Suite 260
Sugar Land, TX 77478
Ph: 281-242-2595 / Fax: 281-242-2909

Consent for Evaluation/Treatment

Client's Name: _____ Date of Birth: _____

I _____, hereby give full consent for child to receive services of Angela M. Pfeiffer, Ph.D. until I notify her or she determines services are no longer appropriate or will no longer be provided. I certify that I have the legal authority to authorize and consent to this treatment or evaluation as parent, managing conservator, or guardian of this child.

CONFIDENTIALITY

I understand that any information I or my child provides to Angela M. Pfeiffer, Ph.D. is confidential and generally will not be released to others without my written consent. However, I understand that professional ethical obligations, state and/or federal law might require Angela M. Pfeiffer, Ph.D. to disclose confidential information without my consent in certain circumstances. I understand Angela M. Pfeiffer, Ph.D. may be required to disclose confidential information, without my consent, in one or more of the following situations:

In the event that the therapy session reveals any information concerning the abuse of a child, elder or disabled person, Angela M. Pfeiffer, Ph.D. is mandated by law to make a report to the proper authorities. By signing this document, I acknowledge my awareness of this fact.

If the course of therapy reveals any intent my child may have to harm either himself/herself or others, I acknowledge Angela M. Pfeiffer, Ph.D.'s legal and moral duty to prevent my child from bringing this harm about. I specifically give my irrevocable permission to warn those parties she feels may be harmed. If my child reveals an intent to harm himself/herself, Angela M. Pfeiffer, Ph.D. has my permission, also irrevocable, to prevent my child from accomplishing that intent.

If my child has been referred to this practice by a managed care or insurance company, or I plan to request Angela M. Pfeiffer, Ph.D. file for reimbursement with a managed care or insurance company, I am aware of this arrangement. As a requirement of the managed care or insurance company, I understand Angela M. Pfeiffer, Ph.D. may be required to provide them with a complete copy of the records generated in my child's therapy. Once these records are in the possession of the managed care or insurance company, Angela M. Pfeiffer, Ph.D. cannot guaranty their continued confidentiality.

Additionally, if a law suit is filed by me or my child against Angela M. Pfeiffer, Ph.D. for breach of duty; or if a court order, legal proceeding, statute, or regulation requires disclosure of records, I understand legal obligations may require the release of my child's therapy records.

RECORDS

I understand it is stated law that psychologists maintain a record of the treatment given to me. This record will contain the information that will allow Angela M. Pfeiffer, Ph.D. to chart the course of therapy. She will use it only for that purpose. It is her intent that no one will ever see what is contained in the file. I understand I may get a copy of the file only by providing her with a signed release of information request. Angela M. Pfeiffer, Ph.D. may provide me with a synopsis of the course of treatment and outcome in lieu of the actual record. I agree I will pay in advance for either the copying cost of the actual record or the time required for the preparation of the treatment summary. This includes providing copies or reports to any court or legal representative or designate.

If the therapy sessions contain more than one patient, I agree that no one person may get the complete treatment file. Angela M. Pfeiffer, Ph.D. will attempt to maintain separate records on each patient. However, only that individual is entitled to his/her own record. I agree Angela M. Pfeiffer, Ph.D. may synopsize the course of each individual's treatment as opposed to providing a copy of what notes may have been made during any therapy session.

If my child has been referred to this practice by a managed care or insurance company, or I plan to request Angela M. Pfeiffer, Ph.D. file for reimbursement with a managed care or insurance company, I am aware that she may have to waive my child's right to confidentiality as it pertains to in the managed care or insurance company. If she is an approved provider, she may have to share all the information I/my child provide with this organization. I understand Angela M. Pfeiffer, Ph.D. will do so as required to get me all the treatment that is appropriate. I am aware that the organization is not bound by her ethical and legal requirements on maintaining the confidentiality my treatment may require. Once these records are in the possession of the managed care or insurance company, Angela M. Pfeiffer, Ph.D. cannot guaranty their continued confidentiality.

In the event that Angela M. Pfeiffer, Ph.D. becomes in capacitated or dies, it will become necessary for another therapist to take possession of your files and records. By signing this form, you give your consent to allow another licensed mental health professional, selected by Dr. Pfeiffer, to take possession of your records and provide you with copies upon request, or to deliver them to a therapist of your choice.

PAYMENT
I understand payment is due at the time of service. Payment schedule will be made known to me before my initial session.

MISSED PAYMENTS
I understand if I do not uphold my responsibility to pay for services, this may result in the termination of treatment with Dr. Pfeiffer and referral for appropriate treatment services elsewhere.

MISSED SESSIONS
If I need to cancel a session with Angela M. Pfeiffer, Ph.D., I agree to provide at least 24 hours notice. If I do not provide this notice, I understand I will be billed $75.00. After 2 sessions in which I failed to give at least 24 hours notice, I will be billed the full amount of the session.

THERAPIST'S INCAPTACITY OR DEATH
In the event that your therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of your files and records. By signing this form, you give your consent to allow another licensed mental health professional selected by your therapist to take possession of your records and provide you with copies upon request, or to deliver them to a therapist of your choice.

TERMINATION OF TREATMENT
I understand the length of time required for therapy will be determined by my child's personal situation. I understand Angela M. Pfeiffer, Ph.D. will do her best to fulfill my therapeutic needs and to provide my child with her best professional care. For my part, I agree to participate in the process as needed to the best of my ability. It is intended that when my child's needs are met, to the extent that they can be, we will terminate our relationship. There is no guarantee of a cure.

I understand I may terminate treatment at any time. This may be accomplished in any one of several ways. These include, but are not limited to, putting it in writing, informing her verbally, failing to maintain my appointment schedule without proper notification, or failure to follow treatment recommendations. I understand Angela M. Pfeiffer, Ph.D. will respect my wishes to terminate treatment. I also understand the method I choose to accomplish termination will impact any decision to resume a therapeutic relationship with her.

My signature on this consent form verifies that I have had the opportunity to ask questions regarding procedures, policies, and therapeutic techniques, that my questions were answered to my satisfaction by Angela M. Pfeiffer, Ph.D., and that I voluntarily give my consent for treatment. I understand that I have the right to withdraw my consent for treatment at any time.

_____	_____	_____
Signature of Parent	Printed Name of Parent	Date
_____	_____	_____
Signature of Parent	Printed Name of Parent	Date

Angela M. Pfeiffer, Ph.D.

12946 Dairy Ashford Rd. Suite 260, Sugar Land, TX 77479 (281) 242-2595, *www.sugarbendcenter.com*
Clinical Psychologist
Texas License Number: 3-0592

INFORMED CONSENT FOR TELEHEALTH SERVICES

Should we decide that telehealth services are appropriate and useful for you and/or your child, please read and sign the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- Please provide a phone number where you or your parent/guardian can be reached in the event of technical problems: _____
- Please provide at least one emergency contact and the closest ER to your location, in the event of a crisis situation.

  Emergency Contact: _____
- If you are not an adult, we need the permission of your parent/legal guardian for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Psychologist Signature: _____

Date signed: _____

Name of Patient: _____

Name of Guardian: _____

Signature of Guardian: _____

Date signed: _____

CHILD / TEEN HISTORY QUESTIONNAIRE

Child's Name: _____ **Today's Date:** _____

Date of Birth: _____ **Child's Age:** _____ **Child's Grade:** _____

Child's School: _____

Mother: _____ **Father:** _____

Other Caregivers: _____

Child's Address: _____
_____

Mother's Address (if different): _____
_____

Father's Address (if different): _____
_____

Home Phone:	_____	**Can I leave a message on this line? Yes No**
Mom's Work Phone:	_____	**Can I leave a message on this line? Yes No**
Dad's Work Phone:	_____	**Can I leave a message on this line? Yes No**
Mom's Cell Phone:	_____	**Can I leave a message on this line? Yes No**
Dad's Cell Phone:	_____	**Can I leave a message on this line? Yes No**
Child's Cell Phone :	_____	**Can I leave a message on this line? Yes No**

Occasionally it is easier to communicate about appointments through email than phone. If you would like the option of communicating about issues such as appointments, scheduling, payments, etc, please list email addresses below. It is important to note, however, that email is not a 100% secure form of communication and thus privacy cannot be guaranteed. Email will not be used for advice, treatment, or any other form of intervention with your provider. By listing email addresses below, you are acknowledging your understanding of these statements.

Mom's email address: _____
Dad's email address: _____
Child's email address: _____

How did you find out about me? _____

Primary Physician's Name: _____
Phone and Fax Number: _____

Please state why you are seeking therapy at this time: _____
_____
_____
_____

At what age was the problem first noticed? _____
_____

What are you hoping to achieve with therapy? _____
_____
_____

ACADEMIC INFORMATION

Is your child in any special programs at school, such as GT, Special Ed, Speech Therapy, Occupational Therapy, Content Mastery, Alternative Schooling, etc.? If so, please describe: _____
_____
_____

Does your child receive any formal or informal modifications at school? Please describe: _____
_____
_____

Do you have concerns about your child's academic performance? Please describe: _____
_____
_____
_____

Has your child had any previous educational, psycho-educational, neuropsychological, or psychological testing? If so, **please bring in a copy of the testing**. Please describe your understanding of the results. _____
_____
_____
_____
_____

If not already described, do you have concerns about your child's behavior at school? Please describe: _____
_____
_____

FAMILY

Please list family members who live in the home and their ages:
_____
_____
_____
_____

Are there any family members who live elsewhere? If so please list their names, ages and reason for moving out:
_____
_____

Mother's highest level of education completed: _____
Mother's employment status: _____

Father's highest level of education completed: _____
Father's employment status: _____

Are parents divorced? Yes No
If so, do you have permission to seek mental health treatment for your child? Yes No

If divorced, is either parent remarried? If so, please list the stepparent names: _____
_____
_____

If divorced, what are the custody arrangements? _____
_____
_____

Are there any parents or step parents who travel frequently? If so, who and how often? _____
_____
_____

Are there any other significant caregivers in your child's life (grandparents, nanny, etc)? _____
_____
_____

RECREATION / SOCIAL

How does your family spend free time?_____
_____
_____

What are your child's favorite hobbies and interests? _____
_____
_____

Does your child have difficulty making and/or keeping friends? If yes, please describe: _____
_____
_____

Please check the following activities in which your child participated in the last month:

- ☐ Exercised or played a sport, how frequently?_____
- ☐ Played with friends outside of school, how frequently? _____
- ☐ Engaged in group activities outside of school, what activities? _____
- ☐ Read or was read to, how frequently? _____
- ☐ Watched TV, how many hours/day?_____
- ☐ Played videogames or computer games, how many hours/day?_____

Do you know of or suspect your child drinks alcohol and/or uses tobacco or any recreational drugs? If so, please describe:_____
_____
_____

Has your child experienced any of the following?

- ☐ Being teased or bullied
- ☐ Teasing or bullying another peer
- ☐ Loss of friendships
- ☐ Change in school setting, teacher, or childcare setting
- ☐ Other: _____

Please describe several strengths your child has: _____
_____
_____
_____

STRESSORS

Has your family experienced any stressful events in the last year? Please check the following.

- ☐ Death in the family
- ☐ Death of a close friend
- ☐ Serious illness or injury, your child
- ☐ Serious illness or injury, a loved one
- ☐ Family fighting
- ☐ Marital problems
- ☐ Divorce or separation
- ☐ Marital reconciliation
- ☐ Problems with child rearing
- ☐ Move to a new home
- ☐ Son or daughter leaves home
- ☐ Conflict with in-laws
- ☐ Change in job - new position, new company, laid off, retired, quit
- ☐ Change in financial status, either more or less money
- ☐ Change in daily responsibilities
- ☐ Change in social network
- ☐ New marriage in the family
- ☐ Outstanding personal achievements

Any other stressors experienced by your child or your family? _____

_____

_____

_____

MEDICAL

Does your child have any of the following medical problems?

Current	Past		Current	Past	
☐	☐	Heart Problems	☐	☐	Head Injury
☐	☐	Digestive Problems	☐	☐	Surgeries
☐	☐	Hypothyroidism	☐	☐	Tics
☐	☐	Hyperthyroidism	☐	☐	High Blood Pressure
☐	☐	Diabetes, Type I	☐	☐	Unexplained pains
☐	☐	Diabetes, Type II	☐	☐	PMS symptoms
☐	☐	Overweight	☐	☐	Muscle tension
☐	☐	Underweight	☐	☐	Headaches
☐	☐	Back or neck pain	☐	☐	Cancer
☐	☐	Alcohol use/abuse	☐	☐	Drug use/abuse

If you checked any of the boxes above, please describe the problem: _____

_____

_____

Are there any other medical problems not listed above that your child experiences? _____

_____

_____

Is your child currently taking any medications? If so, please list: _____

_____

_____

Please describe your child's sleep habits? How many hours per night of sleep are typical for your child? Do you have any concerns about your child's sleep? _____
_____
_____

Please describe your child's eating habits. _____
_____
_____

To your knowledge, does your child use illicit drugs or drink alcohol? Or do you suspect your child may being using drugs or alcohol? Please describe: _____
_____
_____

Are there any medical problems someone in the family has that may be impacting your child? _____
_____
_____

MENTAL HEALTH

How would you describe your child's overall mood? _____

Have you sought psychotherapy for your child or for parenting before? If so, what were the circumstances? _____
_____
_____

Did you find therapy helpful? _____

If your child is taking medication for emotional or behavioral struggles, who is the prescribing physician?_____
_____
_____

Is the medication helpful? _____

Has you child taken medication in the past for emotional or behavioral struggles? If so, what medication(s) and effective was each one? _____
_____
_____

Does you child have any sensory sensitivities that you know of (sensitive to bright lights, noises, textures, etc.)? If so, please describe. _____
_____
_____

Please check all that apply:

	Child, current	Child, past	Mother	Father	Sibling	Other
Depression, sadness						
Anxiety / Excessive Worries						
Autism/PDD/Asperger's						
Tourette's Syndrome						
Panic Attacks						
Obsessions and/or Compulsions						
Suicidal thoughts / Suicide attempt						
PTSD						
Learning Disabilities						
Attention Deficit/Hyperactivity						
Problems with Anger						
Problems with Assertiveness						
Oppositionality/Defiance						
Schizophrenia or Psychosis						
Bipolar or manic episodes						
Heavy Alcohol Use						
Drug Use/Abuse						
Eating Disorder						
Physical or sexual abuse						
Emotional or verbal abuse						
Other:						

Do you have any other comments that you think would be helpful? _____
_____
_____
_____
_____
_____
_____

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PAYMENT AGREEMENT

Self Pay/ Out of Network:

Initial Evaluation	$200	per 60 minutes session
Psychotherapy	$185	per 50-60 minutes session
Group Psychotherapy	$90	per 50-60 minutes session
Class	$90	per 60-minute class
Legal Fees	$300	per hour, $80 per 15 minutes
Including phone time, report/letter writing, travel		
A retainer may be required. Determined on a case-by-case basis		
Copying Records	$1.00	per page
Letters	$80	per 30 minutes

In-Network Benefits:
Your insurance has quoted us the following information on this date: _____. However, information reported to us is not a guarantee of benefits, and benefits are subject to change at any time. We will work under the assumption that the following terms are applicable per verification of your benefits. Should we be informed of insurance nonpayment of services or changes in the information below, you will be notified as soon as possible:

Deductible: _____

Co-Payment/session: _____

Authorization #:_____

Submission of Claims:
Please be advised that our office will make 2 good faith efforts to collect from your insurance company. If unsuccessful, patient will be required to provide payment in full and documentation of unsuccessful efforts will be provided.

Missed Appointments

24 hours notice of cancellation is requested

Less than 24 hours or no notice of cancellation:	$75 fee per late or no notice cancellation
After 3rd missed appointment:	$185 fee per late or no notice cancellation

I understand and agree to all of the above information.

Name of Patient: _____
(please print) *Last* *First* *Middle*

Name of Guardian: _____
(please print) *Last* *First* *Middle*

Signature of Guardian: _____

THIS FORM IS ONLY REQUIRED IF PARENTS WOULD LIKE COMMUNICATION BETWEEN DR. PFEIFFER AND THE CHILD'S SCHOOL

ANGELA M. PFEIFFER, Ph.D.
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Sugar Land, TX 77478
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Consent for Communication with School

Please Complete the Following Information:

_____	_____
Client's Name:	Date of Birth:

SCHOOL INFORMATION

_____	_____
Name of School	School's Phone Number
_____	_____
School's Address	City, State, and Zip
_____	_____
Name of Principal	Name of Counselor
_____	_____
Name of Teacher	Name of Teacher

CONSENT

I, _____, hereby give Angela M. Pfeiffer, Ph.D. permission for the mutual exchange of pertinent information with my child's school personnel, including academic, social, medical, mental health/psychological, and/or psychiatric information.

_____	_____
Signature	Date
_____	_____
Printed Name	Relationship to Patient
_____	_____
Witness	Date

This consent expires one year from the date signed, unless an earlier expiration date is entered here:
_____

THIS FORM IS ONLY REQUIRED IF PARENTS WOULD LIKE COMMUNICATION BETWEEN DR. PFEIFFER AND THE CHILD'S PHYSICIAN

ANGELA M. PFEIFFER, Ph.D.
Clinical Psychologist
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Consent for Communication with Primary Care Provider

Dear Parents:
I an effort to coordinate the care of my patients with their providers in the community, as well as to fulfill insurance obligations, I am requesting your permission to inform your child's primary care physician about your participation in assessment and/or treatment with me. At times, speaking with a child's primary care physician is helpful, especially concerning issues of medication, treatment follow-up, and psychological issues impacting your child's well-being. Moreover, as your child's primary care physician carries the total responsibility for your child's medical care, it is important the physician have access to information related to your child's health and treatment.

_____ _____
Client's Name: Date of Birth:

PHYSICIAN INFORMATION

_____ _____
Name of Physician Physician's Phone Number

_____ _____
Physician's Address City, State, and Zip

CONSENT

☐ I, _____, hereby give Angela M. Pfeiffer, Ph.D. permission for the mutual exchange of pertinent information with my child's primary care physician, including academic, social, medical, psychological, and/or psychiatric information.

☐ I,_____, hereby decline to give Angela M. Pfeiffer, Ph.D. permission for the mutual exchange of pertinent information with my child's primary care physician.

_____ _____
Signature Date

_____ _____
Printed Name Relationship to Patient

_____ _____
Witness Date

This consent expires one year from the date signed, unless an earlier expiration date is entered here:
_____

TO BE COMPLETED BY DIVORCED or DIVORCING PARENT(S) SEEKING TREATMENT FOR CHILD

ANGELA M. PFEIFFER, Ph.D.
Clinical Psychologist
12946 Dairy Ashford, Suite 260
Sugar Land, TX 77478
Ph: 281-242-2595 / Fax: 281-242-2909

Custody Dispute Contract

Client's Name: _____ Date of Birth:_____

The purpose of this contract is to obtain written agreement that the psychologist, Angela M. Pfeiffer, Ph.D. will not be asked to participate in any litigation regarding any custody or access disputes. If Dr. Pfeiffer is asked to participate in any litigation, Dr. Pfeiffer's neutral role with the family may be compromised. This is likely to seriously jeopardize any progress that may have been made in therapy, to hinder likelihood of future progress, and possibly to limit the patient's willingness to seek help from a psychologist at any later time in his/her life. In order to prevent these problems or potential problems, it is crucial that Dr. Pfeiffer, the parents, and the patient have every reassurance that there will be absolutely no involvement on Dr. Pfeiffer's part in any current or future litigation between parents. This is best accomplished by both parents signing this statement:

We wish to enlist the services of Angela M. Pfeiffer, Ph.D., P.C. in the treatment of our child, _____. We understand that such treatment will be compromised if information revealed therein is brought to the attention of the court in the course of a custody dispute. Accordingly, we mutually pledge that we will neither individually nor jointly involve Dr. Pfeiffer in any litigation whatsoever. We will neither request nor require Dr. Pfeiffer to provide testimony in court. We will neither request nor require Dr. Pfeiffer to turn over her notes to the court or any attorneys or other personnel involved in any custody dispute process. If the services of a mental health professional are desired for court purposes, the services of a person other than Dr. Pfeiffer must be enlisted.

_____ _____
Signature of Parent Date

_____
Printed Name of Parent

_____ _____
Signature of Parent Date

_____
Printed Name of Parent

_____ _____
Signature of Witness Date

_____
Printed Name of Witness

TO BE COMPLETED BY DIVORCED PARENT(S) SEEKING TREATMENT FOR CHILD

ANGELA M. PFEIFFER, Ph.D.
Clinical Psychologist
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Documentation of Right to Seek Mental Health Treatment for Child

Client's Name: _____ Date of Birth:_____

By signing below, I certify that I have the legal right to seek mental health treatment for the child identified above. I understand that before treatment can begin I must provide a copy of the divorce decree with the section identifying my right to seek mental health treatment clearly highlighted.

_____ _____
Signature of Parent/Guardian Date

_____
Printed Name of Parent/Guardian

_____ _____
Signature of Parent/Guardian Date

_____
Printed Name of Parent/Guardian

_____ _____
Signature of Witness Date

_____
Printed Name of Witness

ANGELA M. PFEIFFER, PH.D., P.C.
Clinical Psychologist

NOTICE OF PRIVACY PRACTICES

IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT (HITECH), TEXAS MEDICAL PRIVACY ACT (TX HB300), THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AS WELL AS HOW YOU MAY GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY AND SIGN THE ACKNOWLEDGEMENT OF RECEIPT.

Protecting Your Personal and Health Information

This notice will explain how we handle your medical/mental health information. Applicable federal and state laws require us to maintain the privacy of clients' persal and health information. In this Notice, your personal or protected health information is referred to as "health information" or "PHI" and includes information regarding your health care and treatment with identifiable factors, such as your name, age, address, income or other financial information. Because state and federal laws, combined with our professional ethics, are very complicated, some parts of this notice are very detailed and may seem difficult to understand. Please know ANGELA M. PFEIFFER, PH.D., P.C. is committed to protecting the privacy of your health and personal information and is available to answer any questions you may have.

How We Protect Your Health Information

ANGELA M. PFEIFFER, PH.D., P.C. protects your health information by treating all of your health information that she collects as confidential (for exceptions to confidentiality see Uses and Disclosures Not Requiring Consent or Authorization), by training all staff in federal and state confidentiality policies and practices per HIPAA, HITECH, AND TX HB300, by restricting access to your health information only to those office staff that need to know your health information in order to provide service to you, and by maintaining physical, electronic, and procedural safeguards to comply with federal and state regulations guarding your health information. Your health information is maintained on file after termination of services for a minimum of 7 years, or three years after the age of majority, whichever is greater.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

ANGELA M. PFEIFFER, PH.D., P.C. may use or disclose your protected health information for treatment, payment, and health care operations purposes if you have given consent to receive evaluation or treatment services.
Clarification of terms:
PHI- information in your health record that could identify you.
ePHI- information in your health record available in electronic format.
Treatment, Payment, and Health Care Operations
Treatment- when office provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when our office consults with another health care provider, such as your family physician.
Payment- when you provide reimbursement for the services you receive in the office. An example of payment would be when our office discloses your PHI/ePHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
Health Care Operations – are activities that relate to the performance and operation of our office. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, case management and care coordination, and conducting training and educational programs or accreditation activities.
Use – Activities within the office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
Disclosure – Activities outside of the office, such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

ANGELA M. PFEIFFER, PH.D., P.C. and any administrators of her may use or disclose PHI/ePHI for purposes outside Treatment, Payment, or Health Care Operations when your authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when the office is asked for information for purposes outside of Treatment, Payment, or Health Care Operations, we will obtain an authorization from you before releasing this information.
Specific authorization is also obtained before releasing your psychotherapy notes. Psychotherapy notes are notes made about treatment and are given a greater degree of protection than PHI/ePHI.
You may revoke all such authorizations at any time, provided each revocation is in writing. After that time, we will not use or disclose your information for the purposes originally agreed upon. However, we cannot take back any information already disclosed with your permission or that we had used in our office.

Uses and Disclosures Not Requiring Consent or Authorization

The law requires ANGELA M. PFEIFFER, PH.D., P.C. use or disclose PHI/ePHI without your consent or authorization in some

cases. Here are some examples of when this might occur:
When Required by Law - Suspected child abuse must be reported. Also, if you are involved in a lawsuit or legal proceeding and the provider receives a subpoena, discovery request, or other lawful process, some of your PHI/ePHI may have to be released. This will occur only after trying to tell you about the request, consulting your lawyer, or trying to get a court order to protect the information being requested. Finally, some information has to be disclosed to governmental agencies, which check on providers to see that privacy laws are being obeyed.
For Law Enforcement Purposes – Information may be released if your provider is asked to do so by a law enforcement official to investigate a crime or criminal.
For Public Health Activities – Some of your PHI/ePHI might be disclosed to agencies which investigate diseases or injuries.
For Specific Government Functions – PHI/ePHI of military personnel and veterans may be disclosed to government benefit programs relating to eligibility and enrollment. PHI/ePHI may also be disclosed to Workers Compensation and Disability Programs, to correctional facilities if you are an inmate, and for national security reasons.
To Prevent a Serious Threat to Health or Safety – If your provider believes that there is a serious threat to your health or safety or that of another person or the public, the provider can disclose some of your PHI/ePHI. This disclosure will only be provided to persons who can prevent the danger.
Therapist's Incapacity or Death – In the event that your provider becomes incapacitated or dies, it will become necessary for another therapist to take possession of your files and records.

Patient Rights and Provider's Duties

Patient Rights:
Rights to Request Restrictions – You have the right to request that your provider limits what is told to people involved in your care or the payment of your care, such as family members and friends. ANGELA M. PFEIFFER, PH.D., P.C. may not be able to accept your request; however, if accepted she will uphold it except in case of emergency or if it is against the law.
Right to Receive Confidential Communications by Alternative Means/Locations – You have the right to request and receive confidential communications of PHI/ePHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at the office. On your request, communications will be sent to an alternate address.)
Right to Inspect and Copy – You have the right to inspect and/or obtain a copy of your records. A reasonable fee may be charged for copying. Access to your records may be limited or denied under certain circumstances, but in most cases you have a right to request a review of that decision. On your request, we will discuss with you the details of the request and denial process.
Right to Amend – You have the right to request in writing an amendment of your health information for as long as PHI/ePHI records are maintained. The request must identify which information is incorrect and include an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial, which will be added to the information of the original request. If your original request is approved, we will make a reasonable effort to include the amended information in future disclosures. Amending a record does not mean that any portion of your health information will be deleted.
Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI/ePHI. If your health information is disclosed for any reason other than treatment, payment, or operation, you have the right to an accounting for each disclosure of the previous six (6) years. The accounting will include the date, name of person or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.
Electronic vs. Paper – If you received this notice electronically (e.g., accessing a website) you have the right to obtain a paper copy of the notice from the office upon request.

Duties of ANGELA M. PFEIFFER, PH.D., P.C. :
Provider is required by law to maintain the privacy of PHI/ePHI and to provide you with this notice of legal duties and privacy practices.
ANGELA M. PFEIFFER, PH.D., P.C. reserves the right to change the privacy policies and practices and terms of this Notice at any time, as permitted by applicable law. She reserves the right to make the changes in privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Unless we notify you of such changes, however, the office is required to abide by the terms currently in effect.
Provider is also required to notify you if there is a breach of your PHI/ePHI which would allow your clinical or financial information to be identified or compromised.

Questions and Complaints

For questions regarding this Notice of our Privacy Practices, or if you are concerned that your privacy rights may have been violated, please contact ANGELA M. PFEIFFER, PH.D., P.C. . You may also make a written complaint to the US Department of Health and Human Services, whose address can be provided upon request. If you choose to make a complaint with the US Department of Health and Human Services, or with me, I will not retaliate in any way.

ANGELA M. PFEIFFER, PH.D., P.C.
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ANGELA M. PFEIFFER, PH.D., P.C.
Clinical Psychologist

CONSENT FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

In my notice of Privacy Practices, I provide you with information about how I can use or disclose your personal and health information. As described in my Notice of Privacy Practices, I request your consent for use or disclosure of mental health and medical information to carry out treatment, payment, or health care operations. You have a right to review my Notice of Privacy Practices before signing this Consent form.

By signing this Consent form, you: (1) Acknowledge that a copy of the Notice of Privacy Practices has been provided to you; and (2) Consent to our use and disclosure of your health information for treatment, payment, or health care operations, as described in the Notice of Privacy Practices.

You have the right to revoke this Consent in writing any time, except where we have already used or disclosed your health information in reliance upon this Consent.

I am required by law to notify you if there is a breach of your PHI/ePHI which would allow your clinical or financial information to be identified or compromised.

_____
Patient's Name (Printed)

_____ _____
Signature of Patient, Parent, or Legal Representative Date