VISIONS

A Mental Health & Wellness Practice

Welcome!

Thank you for choosing Visions at your mental health provider. Please let me take this opportunity to introduce myself, I am Kimberly Best Johnson. I am the owner and a Licensed Mental Health Professional at Visions, an outpatient mental health and wellness practice.

I have provided information below so you may become acquainted with my clinical background as we will be working to meet your treatment goals.

Education:

- Liberty University, MA, Professional Counseling, 2010 . Old Dominion University, Post graduate certification in Play Therapy, 2012. Clinical Residency: Christian Counseling Associates, 2012

Licensure: Licensed Professional Counselor, Virginia 2013. Licensed Marriage & Family Therapist, Virginia 2013

Certification: Registered Play Therapist

Specialties: Christian Counseling, Marital and Family Relational Challenges, Depression, ADHD, Adjustment Disorders and Anxiety. Additionally, I work with adult women, children with their families and couples.

Personal Interests: Play Therapy, Family Systems, Biblical Studies, Football, Family Time

To help you prepare for your first appointment, I recommend that you contact your health insurance company to understand your benefits, ask if you have EAP benefits which often provides a few sessions FREE to you. Please confirm you are able to work with Visions/ Kimberly Johnson as a provider and ask about your co-payment and any service limits or deductibles. Co-payment as it will be due at the beginning of each appointment.

Please find attached the intake paperwork for you to complete and bring to your first appointment. Please note the intake paperwork is time consuming so please allow sufficient time to give the questionnaires consideration.

- Individual Service Record Form (Please complete and bring to the 1st session)
- Consent to Release and Receive Protected Health Information (Please complete and bring to the 1st session.) It is an industry expectation that therapists coordinate care with their patient's Primary Care Physician.
- Release of Information Consent (Only complete if there is anyone you want Visions to collaborate with in regards to your treatment)
- DSM-5 Self Rated Level 1 Cross-Cutting Symptom Measure-Adult (Please complete and bring to the 1st session)
- Adult Intake Questionnaire (Please complete and bring to the 1st session)
- Outpatient Psychotherapy Patient Information (Patient copy, please keep)
- Notice of Privacy Practices for Protected Health Information (Patient copy, please keep)

When you arrive at the office, the waiting room is located on the left as you enter the office. Please make yourself comfortable, I will come out to get you at your appointment time. Visions looks forward to helping you achieve wellness: Mind . Body . Spirit

Please complete the Prepare Enrich computer based assessment prior to your first session. The assessment allows each of you to share information about your personality, family of origin dynamics, views about life, finances, your faith and marital expectations. Once registered, you will receive an email directly from Prepare Enrich with instructions to pay and complete the assessment. Please complete the assessment prior to our counseling session. The cost of the assessment is $35 per couple. Master Card/Visa or Debit Cards are accepted for payment when you take the test online. You will receive a copy of your assessment on your first appointment as long as you complete your Prepare-Enrich no later than 24 hours prior to your appointment.

*Please take the assessments separately and **do not** share your responses. Also **do not use response (3)**. Response (3) is a considered neutral, it does not provide the best results for our discussion. Do your best to answer the questions based on how you think or feel **most** of the time.

Please find attached intake documents for you to **complete** and **bring** to your appointment, only the release to allow me to coordinate your care with your PCP requires both of you to complete one individually. Completing this paperwork in advance allows us to spend all or your time in session for discussion opposed to completing paperwork.

When you arrive at the office, the waiting room is located on the left as you enter the office. Please make yourself comfortable, I will come out to get you at your appointment time.

Best Regards,

Kimberly Best Johnson, LPC, LMFT ,RPT
Owner
Licensed Marriage & Family Therapist
Licensed Professional Counselor
Registered Play Therapist

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550 Southlake Boulevard
North Chesterfield, VA 23236
Phone: 804-901-5628 Fax: 804-302-7967 www.visionsrva.com

INDIVIDUAL SERVICE RECORD FORM

OFFICE USE

Therapist Name: ☐ Kimberly Best Johnson, LPC, LMFT, RPT ☐ Barbara Evans-Kwamla, LCSW Admission Date:_____/_____/_____

PATIENT INFORMATION

Patient First Name:_____ Middle Name _____ Last Name_____

Sex: M F DOB _____/_____/_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated

If Minor, Legal Guardian(s) Name (s)_____ Custody Type: ☐ Joint ☐ Sole ☐ Guardian

*** A copy of the court order will be necessary if the participating parent/guardian does not have full legal custody of the minor patient**

Home Address: _____ City: _____ State: _____ Zip _____

Employer/School Name_____ Occupation/Grade_____

Preferred Method of Communication ☐ Home ☐ Cell ☐ Work Phone Number_____

Do we have your permission to leave messages? ☐ Y☐ N Text reminders? ☐ Y ☐ N Email _____

What is your primary reason for seeking counseling?_____

Primary Care Physician Name_____ #_____ Permission to coordinate your care? ☐ Y ☐ N

INSURANCE INFORMATION

Subscriber's Name _____ DOB ___/____/___Subscriber's SS#_____

Subscriber's Relationship to Patient: ☐ Self ☐ Parent ☐ Dependent ☐ Spouse Subscriber's Employer_____

Primary Insurance Company_____ Insurance Company's Phone #_____

Insurance ID #_____ Group #_____

Insurance Plan Name:_____ Co-pay $ _____ Deductible? ☐ No ☐ Yes $_____

Is this plan Medicaid? ☐No ☐ Yes ID#_____ EAP _____ Phone #_____

Authorization #_____ # of Sessions Authorized ____ Beginning ___/___/___ Expiring ___/___/___

NAMES OF OTHER FAMILY MEMBERS IN THE HOUSEHOLD

Name	Sex Male	Female	Date of Birth	Relationship to Patient	Covered by your insurance
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

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Welcome to VISIONS. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new Patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your Personal Health Information in greater detail. The law requires that VISIONS obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Outpatient Psychotherapy Services
Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and Patient, and the particular problems you or your child are experiencing. 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 or your child 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 many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Before we begin working together, it is important to understand that I cannot guarantee that you or your child will benefit from therapy. No therapist can make such a guarantee because each Patient responds differently to this experience.

Our first few sessions will involve an evaluation of 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 obtain an appropriate consultation with another mental health professional.

The goals of a psychological evaluation are: a) to provide insight into how you (or your child) is currently functioning, including possibly the evaluation of intellectual potential, academic achievement level, attentional abilities, and/or emotional/ behavioral functioning; b) to diagnose or rule out particular difficulties; and c) to identify strengths. An evaluation may involve the use of a number of procedures such as interviews and psychological questionnaires. Psychological evaluation can have benefits and risks. An evaluation may not answer the questions that motivated the assessment, or it may suggest something that you might find distressing. However, evaluations usually do provide insights that can be valuable in obtaining appropriate care.

Psychotherapy Sessions
The therapist normally conducts an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you or your child need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45 minute session once per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours notice of cancellation (see details under Financial Arrangements section).

Contacting Me
Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office regular hours, I probably will not answer the phone when I am with a Patient. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call as soon as possible. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician, call 911, or call the nearest emergency room and ask for the psychiatrist on-call. If I will be unavailable for an extended time. _____ Initials

Confidentiality
The law protects the privacy of all communications between a Patient and a therapist. In most situations, I can only release information to others about your treatment (or your child's treatment) if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this current agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my Patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel it is important for our work together. I will note all consultations in your Clinical Record.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.
- If a Patient threatens to harm himself / herself, I may be obligated to seek hospitalization for him/her and/or to contact family members, or others who can help provide protection. There are some situations where I am permitted or required to disclose information without either your consent or authorization:

_____ Initials

- If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency. Once such a report is filed, I may be required to provide additional information. _____ Initials

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• If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon him or her, other than by accidental means, or that he or she has been neglected or exploited, I must report to an agency designated by the Department of Human Services. Once I have filed such a report, I may be required to provide additional information. _____ Initials

• If I determine that a patient presents a serious danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim, and /or contacting the police, and/or seeking hospitalization for the Patient. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and will limit my disclosure to what is necessary. 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 now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed. _____ Initials

• If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the therapist /Patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. If a government agency is requesting the information for health oversight activities, I may be required to provide it for them. If a Patient files a complaint or lawsuit against me, I may disclose relevant information regarding that Patient in order to defend myself. If a Patient files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills. There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a Patient's treatment.
_____ Initials

Professional Records

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you or your child in two sets of professional records. One set constitutes your Clinical Record. It includes information about: your reasons for seeking therapy, a description of the ways in which you or your child's problem impacts on your life, diagnosis, the goals that we set for treatment, progress towards those goals, medical and social history, treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself, your child, or others or makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person (or if information is supplied to me confidentially by others), you or your legal representative may examine and /or receive a copy of your or your child's Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I require that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others) which I will discuss with you upon request. In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you or your child with the best treatment. While the contents of Psychotherapy Notes vary from Patient to Patient, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your or your child's therapy. They also contain particularly sensitive information that you or your child may reveal to me that is not required to be included in your Clinical Record and information supplied to me confidentially by others. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you. They also cannot be sent to anyone else, including insurance companies without your written, signed authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

Statement of Patient Rights

HIPAA provides you with several new or expanded rights with regard to your clinical records and disclosures of protected health information. These rights include requesting that I amend your or your child's record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this agreement; the attached notice form, and my privacy policies and procedures. Patients have the right to be treated with dignity and respect. Patients have the right to fair treatment regardless of race, religion, gender, ethnicity, age, disability, or source of payment. Patients have the right to have their treatment and to their information kept private and only disclosed to designated individuals given on a release form signed by the patient. Patients have the right to information from staff/providers in a language they can understand as well as an explanation of their condition and treatment. Patients have the right to know all about their treatment choices regardless of cost coverage. Patients have the right to get information about services offered by their providers and patient role in the treatment process. Patients have the right to request professional information about their provider. Patients have the right to know the clinical guidelines used in providing and/or managing their care. Patients have the right to provide suggestions on office policies and procedure. Patients have the right to complain and to know about the complaint, grievance, and appeals process. Patients have the right to know about State and Federal laws governing their rights and responsibilities. Patients have the right to participate in the formation of their plan of care.

Minors & Parents

Patients under 18 years of age who are not emancipated, as well as their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is typically my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

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FINANCIAL ARRANGEMENTS
PROFESSIONAL FEES

VISIONS has a set of hourly fees $150.00 for the initial session, $100 per 45-50 minute session and $135 for 50-60. You will be expected to pay for each session at the time it is held, **unless you have active insurance coverage or have obtained an EAP authorization which pays for the service**. If you are using health insurance coverage, you are required to pay your copay at the time of service. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. _____ Initials

Other services include report and letter writing, **telephone or email conversations lasting longer than 5 minutes**, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. **These services are not covered by your insurance company and will incur a fee at the hourly rates referenced above.**_____Initials

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. $300 minimum collected upfront, $150 an hour for telephone calls, reports, depositions and preparing medical record copies. _____ Initials

Also, you will be charged for any sessions missed or cancelled with less than 24 hours notice unless due to an emergency situation. The session rate of $50.00 per hour will be charged and payment expected before scheduling the next session _____Initials

In the event of a returned check, there will be a fee of $50.00 assessed which is not covered by insurance. The fee is due prior to scheduling the next session. Visions reserves the right to discontinue accepting checks for payment of services rendered. _____Initials

Your signature below indicates that you have read the professional services agreement, and agree to its terms, and also serves as an acknowledgement that you have received the HIPPA notice form described above.

X_____ Date ____/_____/_____

Patient Signature

X_____ Date ____/_____/_____

Responsible Party Signature if the patient is a minor

X_____ Date ____/_____/_____

Witness or Spouse Signature

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Consent to Release and Receive Protected Health Information

Coordination of Care with Primary Care Physician

Communication between your mental health provider and your primary care physician is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows your mental health provider to share valuable information with your PCP. No information will be released without your signed authorization.

Patient Name_____ **Date of Birth**_____

I hereby authorize the disclosure of protected health information and coordination of care for the individual named above.

I am the: ☐ the patient named above ☐ a personal representative because the patient is a minor, incapacitated, or deceased

Mental Health Professional The following behavioral health provider may disclose and receive the information:

Visions 550 Southlake Boulevard/North Chesterfield, VA 23236/Phone Number (804) 901-5628/Fax (804) 302-7967

☐ **Kimberly Best Johnson, LPC, LMFT, RPT** ☐ **Barbara Evans-Kwamla, LCSW**

Name of Primary Care Physician:_____ Practice Name _____

Phone #:_____ Fax #_____

Street Address _____

City, State and Zip Code:_____

What Information About the Individual Will Be Disclosed?

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis, and medication(s) if necessary.

The Purpose of the Disclosure

To release behavioral health evaluation and/or treatment information to the PCP to ensure quality and coordination of care.

The Expiration Date or Event

This authorization shall expire 1 year from the date of signature below unless revoked prior to that date.

Important Rights and Other Required Statements You Should Know (Please read and initial each statement)

_____You can revoke this authorization at any time by writing to the behavioral health provider named above. If you revoke this authorization, it will not apply to information that has already been used or disclosed.

_____The information disclosed based on this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.

_____You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services.

_____This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.

_____You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting your behavioral health provider named above.

Signature of the Patient _____ Date (required) ____/____/____

Signature of Personal Representative (if applicable) _____ Date (required) ____/____/____

Relationship to the patient (required): ☐ Parent ☐ Legal Guardian ☐ Spouse ☐ Other _____

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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Release of Information Consent

Patient Last Name: _____ First_____ Initial ____ D.O.B._____

I, (Patient or Guardian if minor) _____, authorize Visions and designated staff to: ☐ send ☐ receive the following records from the dates:_____ to _____ to the following.

Company, Agency or Representative Name: _____

Address: _____City: _____State: ____Zip: _____

Phone Number:_____Fax Number:_____

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES.

☐ Academic testing results
☐ Behavior Reports
☐ Grades/ Report Cards
☐ Academic Test Scores/Standardized Test Scores
☐ SPARKS Behavior Checklist
☐ Psycho-educational Evaluation
☐ Psychiatric Evaluation
☐ Psychological Evaluation
☐ Treatment Plans
☐ Court Order/ Probation Documents
☐ Treatment Progress Reports
☐ Social History
☐ Court Order/Documents/Probation
☐ Others, specify _____

The above information will be used for the following purposes:

☐ Planning appropriate treatment or program
☐ Continuing appropriate treatment or program
☐ Determining eligibility for benefits or program
☐ Care Coordination and Case review
☐ Other (specify) _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to patient:☐ Self ☐ Parent/Legal Guardian ☐ Legal representative ☐ Other _____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Patient Signature: _____ Date ____/ _____/ ____

Parent/Legal Guardian/Legal Representative Signature:_____ Date ____/_____/____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: *The questions below ask about things that might have bothered you. For each question, circle the number that best* describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

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Adult Intake Questionnaire

Client Name: Last _____ **First** _____ **Middle** _____ **DOB** _____

Please describe the problem(s) that you want help with: _____

_____

How has this problem affected your life in the following areas?

1. Family _____
2. Work _____
3. Social _____
4. Recreational _____
5. Health _____
6. Spiritually _____

How long have you had this problem? _____

Please list any important events in your life that may relate to this problem:

_____

_____

_____

How serious is this problem? ☐ **mildly** ☐ **moderately** ☐ **very** ☐ **extremely** ☐ **totally**

What have you tried to do to solve this problem? _____

_____

What has been successful? _____

_____

Have you had counseling/therapy in the past? ☐ **Yes** ☐ **No**

If so, where? _____ when? _____

What was helpful about the counseling? _____

What was not helpful about the counseling? _____

MARITAL STATUS: Single ☐ Married ☐ Divorced ☐ How Long? _____

☐ Previously married -- How many times? _____

☐ Living with someone -- How long? _____

☐ Separated -- How long? _____

☐ Widowed -- How long? _____

FAMILY HISTORY:

Who raised you? _____

If there were changes, please list and indicate the age you were when these changes occurred:

_____

_____

Siblings Names/Ages in order of oldest to youngest _____

Which members of your family are you close to? _____

Are there any family members who are a problem for you? _____

Please indicate other people in your life that provide emotional support for you: _____

_____

Choose five words that best describe your childhood 1._____ 2._____

3. _____ 4. _____ 5. _____

Please check any problems that family members have/have had and indicate relationship:

		Relationship to you
☐	Arrests/convictions _____	_____
☐	Alcoholism _____	_____
☐	Depression _____	_____
☐	Violence _____	_____
☐	Drug Addiction_____	_____
☐	Sexual Abuse/Addiction_____	_____
☐	Other mental/emotional problems (list below)	
	_____	_____

Check any of the following that apply to your childhood/adolescence:

☐ Happy childhood	☐ School problems	☐ Medical problems
☐ Unhappy childhood	☐ Family problems	☐ Alcohol use
☐ Drug use	☐ Arrests/convictions	☐ Low Self Esteem

Victim of:		Current	Past			Current	Past
☐	Sexual abuse	____	____	☐	Physical abuse	____	____
☐	Domestic violence	____	____	☐	Emotional abuse	____	____

EDUCATIONAL HISTORY:

Highest Level of Education _____ Course of Study _____

Academic Strengths: _____

_____

Academic Challenges: _____

_____

PHYSICAL AND MENTAL HEALTH:

How would you rate your current health? Very poor 1 2 3 4 5 6 7 8 9 10 Very good

What do you do to take care of yourself physically? _____

List current health problems for which you are receiving treatment: _____

_____

Please your current and previous history of receiving psychiatric/counselingservices _____

_____

List any medications currently prescribed; include the dosage and reason for taking:

_____

What is your current use of alcohol? _____

Have you had problems with alcohol use in the past? Yes ☐ No ☐

If yes, please explain: _____

What is your current use of illegal or other drugs? _____

Have you been arrested for alcohol/drug related offenses? Yes ☐ No ☐ If yes, when? _____

Have you had treatment for problems with alcohol abuse/dependency? Yes ☐ No ☐ If yes, when? _____

Do you have a history of drug use? Yes ☐ No ☐

Have you had treatment for drug abuse/dependency? Yes ☐ No ☐ If yes, when? _____

Have you ever lost a job/relationship due to the use of alcohol/drugs? Yes ☐ No ☐

If yes, please explain: _____

Indicate any of the following that apply to you: If yes provide date and elaborate

Current	Past	
____	____	Thoughts of suicide _____
____	____	Plan for suicide _____
____	____	Suicide attempt _____
____	____	Hurting yourself deliberately _____
____	____	Thoughts of hurting someone else _____

SEVERITY OF PROBLEM: **0=NO PROBLEM 5=DISABLING**	**INDICATE ANY PROBLEMS IN THE FOLLOWING AREAS:**	**EXPLAIN: Frequency/Duration**
0 1 2 3 4 5	Sleep too much	
0 1 2 3 4 5	Sleep too little	
0 1 2 3 4 5	Interrupted sleep	
0 1 2 3 4 5	Other sleep problems	
0 1 2 3 4 5	Memory	
0 1 2 3 4 5	Concentration	
0 1 2 3 4 5	Attention	
0 1 2 3 4 5	Loss of interest in usual activities	
0 1 2 3 4 5	Feelings of sadness	
0 1 2 3 4 5	Loss of energy	
0 1 2 3 4 5	Feeling tired all the time	
0 1 2 3 4 5	Periods of crying	
0 1 2 3 4 5	Feeling of hopelessness	
0 1 2 3 4 5	Loss of sexual desire	
0 1 2 3 4 5	Outbursts of anger	
0 1 2 3 4 5	Change in appetite	
0 1 2 3 4 5	Hearing voices when no person is present	
0 1 2 3 4 5	Unable to recall periods of time in childhood after age 5	
0 1 2 3 4 5	Unable to recall some period of your day	
0 1 2 3 4 5	Walking in sleep	
0 1 2 3 4 5	Nightmares	
0 1 2 3 4 5	Overwhelming fears	
0 1 2 3 4 5	Racing thoughts	
SEVERITY OF PROBLEM: **0=NO PROBLEM 5=DISABLING**	**INDICATE ANY PROBLEMS IN THE FOLLOWING AREAS:** **EXPLAIN: Frequency/Duration**	
0 1 2 3 4 5	Thoughts of harming someone else	

0 1 2 3 4 5	Thoughts of harming yourself
0 1 2 3 4 5	Thoughts that some person or people are trying to harm you
0 1 2 3 4 5	Feelings of being controlled by forces outside yourself
0 1 2 3 4 5	Feeling compelled to repeat activities for no reason
0 1 2 3 4 5	Unable to relax
0 1 2 3 4 5	Blackouts
0 1 2 3 4 5	Excessive sweating
0 1 2 3 4 5	Death of family members or friends
0 1 2 3 4 5	Panic attacks
0 1 2 3 4 5	Mood swings
0 1 2 3 4 5	Spending sprees
0 1 2 3 4 5	Changes in energy level
0 1 2 3 4 5	Other:

WORK HISTORY:

Usual occupation: _____

Are you currently employed: Yes ☐ No ☐ Length of time: _____

Annual Salary $ _____Are you experiencing any financial stressors? If yes, please explain

_____If you have changed jobs during the last five years, give duration of employment and reason for leaving job: _____

_____

Are you happy with your employment situation? Yes ☐ No

_____

PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS

Please rate each of the following problem areas that have been present during the past year or those occurring prior to one year if they clearly contribute to the reasons for seeking treatment. Please write in the specific problem:

0=No significant problem 1=Mild or transient problem 2=Moderate 3=severe 4=Extreme 5=Catastrophic N/A=Unknown or cannot categorize

0 1 2 3 4 5 N/A **Problems with primary support group**: Death of a family member, separation, divorce, removal from home, sexual or physical abuse, discord in the family with parents siblings, or other like events. _____

0 1 2 3 4 5 N/A **Problems related to the social environment**: death or loss of a friend, living alone, discrimination, adjustment to life-cycle transitions, such as leaving home or retirement. _____

0 1 2 3 4 5 N/A **Educational problems:** Unable to read, academic problems, discord with teachers or classmates. _____

0 1 2 3 4 5 N/A **Occupational problems:** Unemployment, threat of job loss, stressful work schedule, discord with boss or co-workers. _____

0 1 2 3 4 5 N/A **Housing problems:** Homeless, unsafe neighborhood, discord with neighbors or landlord. _____

0 1 2 3 4 5 N/A **Economic problems:** Not enough money to pay bills, food and rent. _____

0 1 2 3 4 5 N/A **Problems with access to health care services:** Inadequate health care, transportation to health care facilities unavailable, inadequate health insurance. _____

0 1 2 3 4 5 N/A **Problems related to interaction with the legal system/crime:** Arrest, incarceration, litigation, victim of a crime. _____

0 1 2 3 4 5 N/A **Other psychosocial and environmental problems:** Exposure to disasters, discord with non-family caregivers such as counselor, social worker or physician, unavailability of social service agencies. _____

Is there anything else you would like to share to aid in better understanding your situation?_____

What would you like to gain as a result of counseling? _____

If you had 3 wishes, what would they be? This helps us determine treatment goals

1._____

2._____

3._____

Visions therapists have specialized training and experience in Christian counseling practices, do you want to incorporate this speciality into your treatment. Yes ☐ No ☐

VISIONS

A Mental Health & Wellness Practice

Outpatient Psychotherapy Patient Information

Welcome to Visions! We appreciate your giving us the opportunity to be of help to you.

This brochure answers some questions patients often ask about any therapy practice. It is important to me that you know how we will work together. We believe our work will be most helpful to you when you have a clear idea of what we are trying to do.

- This brochure talks about the following in a general way:
- What the risks and benefits of therapy are.
- What the goals of therapy are and what our methods of treatment are like.
- How long therapy might take.
- How much our services cost, and how we handle money matters.
- Other important areas of our relationship.

After you read this brochure we can discuss, in person, how these issues apply to your own situation. This brochure is yours to keep and refer to later. Please read all of it and mark any parts that are not clear to you. Write down any questions you think of, and we will discuss them at our next meeting. When you have read and fully understood this brochure, we will ask you to sign it at the end. We will sign it as well and make a copy, so we each have one.

About Psychotherapy

Because you will be putting a good deal of time, money, and energy into therapy, you should choose a therapist carefully. We strongly believe you should feel comfortable with the therapist you choose, and hopeful about the therapy. When you feel this way, therapy is more likely to be very helpful to you.

In our treatment plan we work together to decide on the areas to work on, our goals, the methods we will use, the time and money commitments we will make, and some other things. We expect to agree on a plan that we will both work hard to follow. From week to week, we will look together at your progress and goals, and how the therapeutic relationship is working for you. If we think we need to, we can then change our treatment plan, its goals, and its methods, or even the therapist that you work with.

An important part of your therapy will be practicing new skills that you will learn in our sessions. You will probably have to work on relationships in your life and make long-term efforts to get the best results. These are important parts of personal change. Change will sometimes be easy and quick, but more often it will be slow and frustrating, and you will need to keep trying. There are no instant, painless cures and no "magic pills." However, you *can* learn new ways of looking at your problems that will be very helpful for changing your feelings and reactions.

Patients typically come in once a week for 3 to 4 months. After that, we meet less often for several more months. Therapy then usually comes to an end. The process of ending therapy, called "termination," can be a very valuable part of our work. Stopping therapy should not be done casually, although either of us may decide to end it if we believe it is in your best interest. If you wish to stop therapy at any time, we ask that you agree now to meet then for at least one session to review our work together. We will review your goals, the work we have done, any future work that needs to be done, and your choices. If you would like to take a "time out" from therapy to try it on your own, we should discuss this. We can often make such a "time out" be more helpful.

We will send you a brief set of questions after our last session. These questions will ask you to look back at our work together. We ask that you agree to return this follow-up form and to be very honest about what you tell us.

The Benefits and Risks of Therapy

As with any powerful treatment, there are some risks as well as many benefits with therapy. You should think about both the benefits and risks when making any treatment decisions. For example, in therapy, there is a risk that patients will, for a time, have uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other negative feelings. Patients may recall unpleasant memories. These feelings or memories may bother a patient at work or in school. Also, patients in therapy may have problems with people important to them. Family secrets may be told. Therapy may disrupt a marital relationship and sometimes may even lead to a divorce. Occasionally, a patient's problems may temporarily worsen after the beginning of treatment. Most of these risks are to be expected when people are making important changes in their lives. Finally, even with our best efforts, there is a risk that therapy may not work out well for you.

While you consider these risks, you should know also that the benefits of therapy have been shown by scientists in hundreds of well-designed research studies. People who are depressed may find their mood lifting. Others may no longer feel afraid, angry, or anxious. In therapy, people have a chance to talk things out fully until their feelings are relieved or the problems are solved. Patients' relationships and coping skills may improve greatly. They may get more satisfaction out of social and family relationships. Their personal goals and values may become clearer. They may grow in many directions—as persons, in their close relationships, in their work or schooling, and in the ability to enjoy their lives.

Therefore, we will enter our relationship with optimism about your progress.

Consultations

If you could benefit from a treatment we cannot provide, we will help you to get it. You have a right to ask me about such other treatments, their risks, and their benefits. Based on what we learn about your problems, we may recommend a medical exam or use of medication. If we do this, we will fully discuss our reasons with you,

so that you can decide what is best. If you are treated by another professional, we will coordinate our services with them and with your own medical doctor as needed.

If for some reason treatment is not going well, we might suggest you see another therapist or another professional in instead of or addition to the therapist you start with. We cannot continue to treat you if our treatment is not working for you. If you wish for another professional's opinion at any time, or wish to talk with another therapist within this organization or elsewhere, we will help you find a qualified person and will provide him or her with the information needed with your consent.

What to Expect from Our Relationship

As professionals, we will use our best knowledge and skills to help you.
First, we are licensed and trained to practice mental health services, —not law, medicine, finance, or any other services. We are not able to give you good advice from these other professional viewpoints.

Second, federal and state laws and the rules of the professional organizations governing our agency require us to keep what you tell me confidential (that is, private). You can trust us not to tell anyone else what you tell us, except in certain limited situations. We explain what those are in the "About Confidentiality" section of this brochure. Here we want to explain that we try not to reveal who our patients are. This is part of our effort to maintain your privacy. If we meet on the street or socially, we may not say hello or talk to you very much. Our behavior will not be a personal reaction to you, but a way to maintain the confidentiality of our relationship.

Third, in your best interest, and following the APA's standards, we can only be your therapist. We cannot have any other role in your life. We cannot, now or ever, be a close friend or socialize with any of our patients. We cannot be a therapist to someone who is already a friend. We can never have a sexual or romantic relationship with any patient during, or after, the course of therapy. We cannot have a business relationship with any of our patients, other than the therapy relationship.

Even though you might invite us, we cannot attend your family gatherings, such as parties or weddings.

As your therapist, we will not celebrate holidays or give you gifts; we may not notice or recall your birthday; and may not receive any of your gifts eagerly.

About Confidentiality

We will treat with great care all the information you share with us. It is your legal right that our sessions and our records about you are kept private. That is why we ask you to sign a "release-of-records" form before we can talk about you or send our records about you to anyone else. In general, we will tell no one what you tell us. We will not even reveal that you are receiving treatment from us.

In all but a few rare situations, your confidentiality (that is, your privacy) is protected by state law and by the rules of our profession. Here are the most common cases in which confidentiality is *not* protected:

1. If you were sent to us by a court or an employer for evaluation or treatment, the court or employer expects a report from us. If this is your situation, please talk with us before you tell us anything you do not want the court or your employer to know. You have a right to tell us only what you are comfortable with telling.

2. Are you suing someone or being sued? Are you being charged with a crime? If so, and you tell the court that you are seeing us, we may then be ordered to show the court our records. Please consult your lawyer about these issues.

3. If you make a serious threat to harm yourself or another person, the law requires us to try to protect you or that other person. This usually means telling others about the threat. We cannot promise never to tell others about threats you make.

4. If we believe a child has been or will be abused or neglected, we are legally required to report this to the authorities.

There are two situations in which we might talk about part of your case with another therapist. We ask now for your understanding and agreement to let us do so in these two situations.

First, when we are away from the office for a few days, we have a trusted fellow therapist "cover." This therapist will be available to you in emergencies. Therefore, he or she needs to know about you. Of course, this therapist is bound by the same laws and rules as we aim to protect your confidentiality.

Second, we sometimes consult other therapists or other professionals or supervisors about our patients. This helps us in giving high-quality treatment. These persons are also required to keep your information private.

For the purpose of these consultations, we may want to make audio or video recordings of our sessions. We will review the recordings with our consultant to assist with your treatment. We will ask your permission to make any recording. We promise to destroy each recording as soon as we no longer need it, or, at the latest, when we destroy your case records. You can refuse to allow this recording, or can insist that the recording be edited.

Except for the situations we have described above, our office staff and we will always maintain your privacy. We also ask you not to disclose the name or identity of any other patient being seen in this office.

Our office staff makes every effort to keep the names and records of patients private. Our staff and we will try never to use your name on the telephone, if patients in the office can overhear it. All staff members who see your records have been trained in how to keep records confidential.

If your records need to be seen by another professional outside of our agency, or anyone else, we will discuss it with you. If you agree to share these records, you will need to sign a release form. This form states exactly what information is to be shared, and with whom, and it also sets time limits. You may read this form at any time. If you have questions, please ask.

It is our office policy to destroy patients' records 7 years after the end of our therapy. Until then, we will keep your case records in a safe place.

If we must discontinue our relationship because of illness, disability, or other presently unforeseen circumstances, we ask you to agree to our transferring your records to another therapist who will assure their confidentiality, preservation, and appropriate access.

If we do family or couple therapy (where there is more than one patient), and you want to have our records of this therapy sent to anyone, all of the adults present will have to sign a release.

As part of cost control efforts, an insurance company will sometimes ask for more information on symptoms, diagnoses, and our treatment methods. It will become part of your permanent medical record. Please understand that we have no control over how these records are handled at the insurance company. Our policy is to provide only as much information as the insurance company will need to pay your benefits.

You can review your own records in our files at any time. You may add to them or correct them, and you can have copies of them. We ask you to understand and agree that you may not examine records created by anyone else and sent to me.

In some very rare situations, we may temporarily remove parts of your records before you see them. This would happen if we believe that the information will be harmful to you, but we will discuss this with you.

Other Points

We request that you do not bring children with you if they are young and need babysitting or supervision, which we cannot provide.

If you ever become involved in a divorce or custody dispute, we want you to understand and agree that we will not provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on two reasons: (1) Our statements will be seen as biased in your favor because we have a therapy relationship; and (2) the testimony might affect our therapy relationship, and we must put this relationship first.

If, as part of our therapy, you create and provide to me records, notes, artworks, or any other documents or materials, we will return the originals to you at your written request but will retain copies.

Statement of Principles and Complaint Procedures

Problems can arise in our relationship, just as in any other relationship. If you are not satisfied with any area of our work, please raise your concerns with me at once. Our work together will be slower and harder if your concerns are not worked out. We will make every effort to hear any complaints you have and to seek solutions to them. If you feel that I, or any other therapist, has treated you unfairly or has even broken a professional rule, please tell me. You can also contact the state or local psychological association and speak to the chairperson of the ethics committee. He or she can help clarify your concerns or tell you how to file a complaint. You may also contact the state board of psychologist examiners [note that this name differs across states], the organization that licenses those of us in the independent practice of psychology.

In our practice as a therapist, we do not discriminate against patients because of any of these factors: age, sex, marital/family status, race, color, religious beliefs, ethnic origin, place of residence, veteran status, physical disability, health status, sexual orientation, or criminal record unrelated to present dangerousness. This is a personal commitment, as well as being required by federal, state, and local laws and regulations. We will always take steps to advance and support the values of equal opportunity, human dignity, and racial/ethnic/cultural diversity. If you believe you have been discriminated against, please bring this matter to our attention immediately.

Notice of Privacy Practices for Protected Health Information

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.

VISIONS is providing this Notice of Privacy Policies & Practices because the privacy of your health information is very important to you and to us. This Notice complies with the Federal regulations regarding the privacy of your health information. By "your health information" we mean the information that we maintain that specifically identifies you and your health status.

Summary
This Notice describes how we use your health information within VISIONS and disclose it outside VISIONS, and why.

The Notice covers:
A. Uses or disclosures which do not require your written authorization;
    1. Treatment, payment, and health care operations.
    2. Uses or disclosures of your health information to which you may object.
    3. Uses or disclosures required or permitted.
B. Uses or disclosures which require your written authorization.
C. Your rights as a client regarding privacy of your health information.
D. Our duties in protecting your health information.
E. Uses of your health information to which you may object.
F. Uses or Disclosures Required or Permitted
G. Requests, complaints, contact person, effective date, and acknowledgment.

Uses or disclosures which do not require your written authorization

A. Treatment, Payment, and Health Care Operations
We use or disclose your health information to carry out your treatment; to obtain payment for your treatment; and to conduct health care operations. For example:

- For Treatment: we use your health information to plan, coordinate, and provide your care and treatment. We disclose your health information to physicians and other health care professionals outside our agency who are involved in your care. And we disclose your health information to bill Medicaid or other third parties for payment for your care and treatment.
- For payment: we use your health information to prepare documentation required by your insurance company or HMO or by Medicaid. We disclose that part of your health information that these organizations require to pay us.

• For health care operations: we use or disclose your health information, for example, to improve the quality of our services, to plan better ways of treating clients, and to evaluate staff performance.

B. Uses or disclosures which require your written authorization

Your written authorization, which you may revoke (in writing), is required if we use or disclose your health information for any purpose other than for treatment, payment or health care operation, unless required by law or otherwise provided in the Federal regulation as set forth below, in particular:

1. Our use of psychotherapy notes beyond treatment, payment, and health care operations.
2. Marketing of goods or services to you.
3. Disclosure to any persons other than those listed in item E, below.
4. Disclosure to persons through the Agency website with a special access code.

C. **Your rights as a client to privacy of your health information**

1. Right to Request Restrictions

You have the right to request restrictions on our uses and disclosures of your health information; however we may refuse to accept the restriction.

2. Right to Request Confidential Communications

You have the right to request that we communicate with you confidentially, for example to speak with you only in private; to send mail to an address you designate; or to telephone you at a number you designate. Your request must be in writing. We will make every attempt to honor your request.

3. Right to Request Access to Your Health Information

You have the right to request access to your health information in order to inspect or copy it. Your request must be in writing. We may deny your request and, if so, you may request a review of the denial. However, we will make every attempt to honor your request.

You may ask Agency caregiver for an Access Request form and a copy of the Access Procedures at any time.

4. Right to Request an Amendment of Your Health Information

You have the right to request an amendment to your health information. Your request must be in writing and must provide a reason for the amendment. We may deny your request and, if so, you may submit a statement of disagreement. However, we will make every attempt to honor your request.

5. Right to Request an Accounting of Disclosures of Your Health Information

You have the right to request an accounting of our disclosures of your health information for purposes other than treatment, payment, and health care operations. We will make every attempt to honor your request.

6. Right to Obtain a Paper Copy of this Notice

If you received this Notice electronically, you have the right to receive a paper copy, and you may request a paper copy from the Agency. The Agency has a form for your use in exercising any of these rights. To exercise any of these rights, you may contact the Agency staff; or you may write or call the Agency's Adminsistrator.

D. **Our Duties in Protecting Your Health Information**

1. We are required by law to maintain the privacy of your health information.

2. We must inform clients or their legal representatives of our legal duties and privacy practices with respect to health information. This Notice discharges that duty.
3. We must abide by the terms of the Notice currently in effect.
4. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that we maintain. At any time, you may obtain a copy of the current notice from the Administrator.
5. The Agency may not require or request you to waive your rights under the Privacy Rule as a condition of the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits.

E. **Uses or Disclosures of Your Health Information to Which You May Object**

We may use or disclose your health information for the following purposes, unless you object and request we not. Your objections, if any, and any restrictions or authorizations you wish to place on the disclosure of your health information will be recorded by the Agency.

1. Informing family and friends: disclosures of your health information to family, friends, or others identified by you who are involved in your care.
2. Assistance in disaster relief efforts.
3. Confirming our visits to your home or other appointments.
4. Informing you about treatment alternatives or other health-related benefits and services that may be of interest to you.

F. Uses or Disclosures Required or Permitted Without Your Authorization

Where we are required or permitted to do so, we may use or disclose your health information in the following circumstances without your written authorization.

1. Federal government investigation, when required by the Secretary of Health and Human Services to investigate or determine our compliance with federal regulation.
2. Federal, state or local law requirements.
3. Public health activities, for example to report communicable diseases or death; or for matters involving the Food and Drug Administration.
4. Reporting of abuse, neglect or domestic violence.
5. Health oversight activities by a health oversight agency. (A health oversight agency is an organization authorized by the government to oversee eligibility and compliance and to enforce civil rights laws.)
6. Judicial or administrative proceedings, for example responding to a court order or subpoena.
7. Law enforcement purposes, for example to report certain types of wounds or other physical injuries or to identify or locate a suspect, fugitive, material witness, or missing person.
8. Use by coroners, medical examiners, or funeral directors.
9. Facilitating organ, eye, or tissue donation.
10. Research, provided that very strict controls are enforced.
11. Averting a serious threat to your health or safety or that of the public.
12. Specialized government functions such as military or veterans' affairs; national security, and intelligence activities.
13. Counselors' compensation.

G. Requests, Complaints, Contact Person, Effective Date, and Acknowledgment

1. You have the right to lodge a complaint with the Agency and/or with the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.
2. You will not be retaliated against for filing a complaint.
3. Complaints must be filed in writing, and may be received by mail, fax, or email. You may make any requests, obtain additional information, or file a complaint with our Agency by writing to the Agency Compliance Officer:

Kimberly Best Johnson, Privacy Officer
VISIONS
550 Southlake Boulevard
North Chesterfield, VA 23236
(804) 901-5628
Fax (804) 302-7967
kbestjohnson@visionsrva.com

4. You may file a complaint with the Secretary of Health and Human Services by writing to:

Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

This notice is effective February 1, 2014