Brynna Levin Sibilla, M.S.W.
Licensed Clinical Social Worker
1934 N.E. Broadway Portland, OR 97232
503-280-1101

Office Policies and Procedures

Below you will find an explanation of the administrative details of this office. I am providing this information in an effort to save time, but encourage you to discuss any questions or concerns about these matters with me. Our mutual agreement is an important first step in our work together. Thank you for your time and attention.

Confidentiality: Your participation in treatment and all information about you is confidential and will not be disclosed to anyone without your written consent. The only exceptions are: 1) Cases of suspected abuse or neglect of a child or elder, 2) Cases where I believe you present a clear and imminent danger yourself or to another person, 3) Cases where a court subpoenas me to testify or subpoenas my records, 4) Cases where an insurance company is helping to pay the fee and requires information about diagnosis and /or reports about treatment.

Fees and Billing: The fee for my professional services is $160 for an individual session if you are paying in full at the time of service (or if mailed to me directly following a phone session). It is $180 (1st session $200) per session if I am billing an insurance company. You will be charged at this same rate for additional services provided at your request or for your benefit (at the request of an insurance company, attorney etc) such as report writing, consultation with other professionals, phone calls over ten minutes with you or others. Payment is expected at the time of the visit unless other arrangements are made with me, in writing, in advance of the appointment. Ultimately, if you do not pay as agreed, your account may be turned over to an attorney or collection agency. In that circumstance, your confidentiality will, by necessity, be breached.

Appointments/communication: Your appointment time is held exclusively for you. You need to contact my officee at least 24 hours in advance in order to cancel or change your appointment. Otherwise, you will be charged in full for the session. Insurance companies do not reimburse for missed sessions. I rely on voicemail or email for communication. By signing below you authorize me to leave voice messages or emails regarding appointment dates and times for you at the number/email you provide below. If you request that I communicate with you via email other than Hushmail I limit those messages to appointment date and time information and do not respond to other content as email is not secure/confidential. I do not text with clients.

Internet: I do not accept "friend or follow " requests on Facebook, Instagrram or other social media sites.

Insurance: Please consult your policy for your coverage of outpatient psychotherapy with a licensed clinical social worker. If your insurance covers my services I will bill your carrier for you providing whatever clinical information they may need. I consider your insurance company to be under contract with you, and therefore you are responsible for tracking this coverage as treatment progresses. Likewise, I consider you to have an agreement with me and consider you to be responsible for the entire bill whether the insurance company pays or not.

Emergencies: In case of an urgent situation you may leave a message on my answering machine as I check it throughout the day. If you need immediate support before I call, you may contact Multnomah Mental Health Crisis @503-988-4888. In the event of a life threatening situation call 911 or go to the nearest emergency room. When I am out of town another licensed therapist will be on call, should the need arise.

Consent to Treatment: Your signature below indicates that you have read and agree to services under the conditions listed above. If, at any time, you have concerns or questions regarding your treatment, please discuss them with me. You have the right to request changes or to refuse treatment at any time.

_____ Address:_____
Signature Date

_____

Phone# _____

_____
Email address

_____
Emergency Contact, relationship Phone# _____

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Confidential Client Information

Identifying Information

Client's Name:_____ First Appt. Date:_____
Gender:_____Age:____ Birth Date:_____ Driver's License:_____
Home Address: _____City/State: _____ Zip____
Telephone:_____ OK to leave messages? Y/N
Email: _____

Others living in the home:

Name	Age:	Relationship to client

	High School	College	Technical	Graduate
Education:	1-2-3-4-5-6-7-8-9-10-11-12	13-14-15-16	Y/N	Degree:_____

Your Employer:_____ Occupation:_____
How long at current job:_____ Military History:_____

Marital Status:_____ Spouse/Partner's Name:_____ Age:___
Children's Names & Ages:_____
_____
Emergency contact:_____
Name Relationship Telephone

Client Name:_____

Presenting Problem

Please describe the problem(s) that brought you here and when this began to negatively affect you.

_____
_____
_____
_____
_____
_____
_____
_____

To what degree have the problems you're dealing with affected you in the following areas :

Work/Study: ___No impact ___ Moderate Impact ___Significant Impact
Physical Health: ____No impact ___Moderate Impact___Significant Impact
Family: ___No impact ___Moderate Impact ___Significant Impact
Social: ___No impact ___Moderate Impact ___Significant Impact

What have you tried to resolve the problem?

_____
_____

How will you know if therapy has been successful?

_____
_____

What are your top goals for therapy?

_____
_____
_____
_____

Brynna Siblla, LCSW 1934 NE Broadway * Portland, OR 97232 * 503-280-1101

Client Name _____

Current Symptoms

Please **circle the number** to rate the following symptoms according to the degree to which they are troubling your current life. Also, **in the blank,** indicate **how long** these problems have affected you.

Scale **1=extremely big problem** **6= little or no concern**

MOOD	1	2	3	4	5	6	_____	IMPULSE Control	1	2	3	4	5	6	_____
Tiredness	1	2	3	4	5	6	_____	Anger	1	2	3	4	5	6	_____
Inferiority Feelings	1	2	3	4	5	6	_____	Temper	1	2	3	4	5	6	_____
Concentration	1	2	3	4	5	6	_____	Hurting others	1	2	3	4	5	6	_____
Appetite	1	2	3	4	5	6	_____	Hurting self	1	2	3	4	5	6	_____
Weight Gain/Loss	1	2	3	4	5	6	_____	Dangerous behavior	1	2	3	4	5	6	_____
amount in last month							_____	SUBSTANCE USE	1	2	3	4	5	6	_____
Sleep	1	2	3	4	5	6	_____	Alcohol	1	2	3	4	5	6	_____
Nightmares	1	2	3	4	5	6	_____	Drinks/week							_____
Insomnia	1	2	3	4	5	6	_____	Drugs	1	2	3	4	5	6	_____
Ambition	1	2	3	4	5	6	_____	Caffeine	1	2	3	4	5	6	_____
Unhappiness	1	2	3	4	5	6	_____	Drinks/week							_____
Irritability	1	2	3	4	5	6	_____	Tobacco	1	2	3	4	5	6	_____
Depression	1	2	3	4	5	6	_____	Packs/week							_____
Manic Behavior	1	2	3	4	5	6	_____	RELATIONSHIPS	1	2	3	4	5	6	_____
Suicidal Thoughts	1	2	3	4	5	6	_____	Friends	1	2	3	4	5	6	_____
ANXIETY	1	2	3	4	5	6	_____	Marriage	1	2	3	4	5	6	_____
Nervousness	1	2	3	4	5	6	_____	Separation/Divorce	1	2	3	4	5	6	_____
Panic Attacks	1	2	3	4	5	6	_____	Children	1	2	3	4	5	6	_____
Compulsive Behavior	1	2	3	4	5	6	_____	Shyness	1	2	3	4	5	6	_____
Obsessive Thoughts	1	2	3	4	5	6	_____	Loneliness	1	2	3	4	5	6	_____
Fears	1	2	3	4	5	6	_____	Fear of being alone	1	2	3	4	5	6	_____
HEALTH	1	2	3	4	5	6	_____	Distancing others	1	2	3	4	5	6	_____
Bowel Troubles	1	2	3	4	5	6	_____	SEXUAL Problems	1	2	3	4	5	6	_____
Headaches	1	2	3	4	5	6	_____	SELF CARE	1	2	3	4	5	6	_____
Stomach Trouble	1	2	3	4	5	6	_____	Work	1	2	3	4	5	6	_____
Binging/Purging	1	2	3	4	5	6	_____	Career Choices	1	2	3	4	5	6	_____
THOUGHTS	1	2	3	4	5	6	_____	Education	1	2	3	4	5	6	_____
Making Decisions	1	2	3	4	5	6	_____	Legal Matter	1	2	3	4	5	6	_____
Memory	1	2	3	4	5	6	_____	Finances	1	2	3	4	5	6	_____
Confusion	1	2	3	4	5	6	_____	Stress	1	2	3	4	5	6	_____
Communicating	1	2	3	4	5	6	_____	Incest	1	2	3	4	5	6	_____

Client Name _____

THERAPY HISTORY

Have you ever been in therapy/counseling before? Yes ____ No ____
If Yes, how many times _____
Have you ever been hospitalized for psychological or emotional problems? Yes ____ No _____
If Yes, how many times _____

If Yes to either question above, please describe your experience(s) below beginning with the most recent previous episode of treatment.

Treatment Episode:
When did you see the counselor (your age or dates): _____
Who did you see: _____
Did you go alone or with others? _____
What problems were addressed? _____
_____
_____
What did you like or gain from the experience? _____
What did you not like about it? _____

Treatment Episode:
When did you see the counselor (your age or dates): _____
Who did you see: _____
Did you go alone or with others? _____
What problems were addressed? _____
_____
_____
What did you like or gain from the experience? _____
What did you not like about it? _____

Treatment Episode:
When did you see the counselor (your age or dates): _____
Who did you see: _____
Did you go alone or with others? _____
What problems were addressed? _____
_____
_____
What did you like or gain from the experience? _____
What did you not like about it? _____

(Please use an additional page if you have other past therapy/counseling experiences to report.)

Client Name _____

FAMILY BACKGROUND

Where did you grow up and who did you live with?

_____
_____
_____
_____

How would you describe your childhood?

_____
_____

What problems did your family have? What strengths?

_____
_____

Who are you closest to today?

_____
_____

Please describe any family history (past or present)of psychological or emotional problems.

_____
_____
_____
_____

MEDICAL INFORMATION

Have you seen a doctor in the last year? Yes ____ No ____

If Yes, for what problems? _____
_____

Who is your Primary Doctor? _____ Doctor's phone: _____

Please list any medications you are taking now including dosage and frequency:

_____
_____

Do you have any allergies? Yes ____ No _____

Have you ever been treated in a hospital?

If Yes, for what problems? _____
_____
_____

Have you ever been in an accident or suffered any kind of physical/emotional/sexual trauma?
Yes ___ No ____

Please give brief description of kind of trauma and when it happened: _____
_____

What kind of treatment did you receive, if any? _____

Have you ever had a head injury? Yes ____ No _____

Other serious medical conditions past or present:

_____
_____

Client Name _____

SUBSTANCE USE HISTORY

Do you use/have you used alcohol? O Current O Past O No

Alcohol Frequency:

O Never O Less than 1 time/month O 1-4 times/month O 2-3 times/week O Daily

Usual Alcohol Consumption:

O None O 1-2 drinks per sitting O 3-4 drinks/sitting O 5 or more drinks per sitting

Intoxication Frequency:

O Never O Less than 1 time/month O 1-4 times/month O 2-3 times/week O Daily

Other Substance Use: (Check all used in past 6 months)

O None O Marijuana O Sedatives O Stimulants (speed, crank, etc)
O Cocaine O Inhalents O Opiates O Hallucinogens (LSD, Ecstasy)
O Prescription Drugs

O Caffeine (number of cups/day) _____
O Tobacco (number of cigarettes/day) _____

Alcohol or other drug related problems:

O Binges O Job Problems O Sleep Disturbances O Physical Withdrawal
O Hangover O Legal Problems O Blackouts/memory lapse O Medical Concerns
O Seizures O Problems with Friends/Family O Assaults O Changes in Tolerance
O Inability to stop after first drink/use O Passing Out O Concern over use

History of Substance Abuse Treatment:

O None O Stopped on own O Attended AA/other 12-step program
O Attended In-patient O Attended Out-patient O Attended community based program

Please describe treatment received and outcome:

_____

_____

Please describe any family substance abuse history:

_____

_____

Other impulsive/addictive concerns:

____ Problem gambling _____ Impulsive spending/shopping _____ Pornography
_____ Internet Surfing _____ Excessive Television viewing _____Impulsive eating

COORDINATION WITH OTHER SERVICES:

Please indicate if there are other agencies/service providers with whom you are currently working with:

Other Mental Health Provider: _____ Attorney: _____
Physician: _____ Juvenile Dept.: _____
Corrections: _____ Child Protective Services: _____
Career Counselor: _____ Employee Assistance Program: _____

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Telemental Health Informed Consent

I _____, (name of client) hereby consent to participate in telemental health with Brynna Sibilla LCSW (name of provider) as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risk and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at 503.280.1101 to discuss since we may have to re-schedule.

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7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

and my emergency contact person's name, address, phone: _____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of therapist Date

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

SECOND FOLD

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

X SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

X SIGNED _____

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJ PR

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY TO

17. NAME OF REFERRING PHYSIC

ED TO CURRENT SERVICES MM DD YY TO

19. RESERVED FOR LOCAL USE

$ CHARGES

21. DIAGNOSIS OR NATURE OF I

1. ____ . ____

2. ____ . ____

INAL REF. NO.

Fill in boxes above center line

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD

	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	NPI	
2	NPI	
3	NPI	
4	NPI	
5	NPI	
6	NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH. # ( )

a. b.

Brynna Levin Sibilla, M.S.W.
Licensed Clinical Social Worker
Blue Heron Chiropractic & Healing Arts Center
1934 N.E. Broadway
Portland, OR 97232

Consent for Release of Confidential Information

X I _____ authorize my therapist, Brynna Sibilla, LCSW, to disclose to and receive information from:

(name of person or institution) _____

Address _____

_____

Phone number _____

The nature and extent of the information may include psychological, psychiatric, medical (including alcohol, drug abuse, HIV and/or AIDS information/testing results if applicable), educational, historical, legal, social, financial or employment .

It is understood that all information received by my therapist as a result of this authorization will be treated as confidential and will be used for the express purpose of diagnostic evaluation, treatment planning, case coordination, providing written and/or verbal evaluations, reports, recommendations, and/or _____.

I have read the above, fully understand its contents having asked questions about anything that was unclear to me and am satisfied with the answer I have received.

This authorization is valid for one year from the date of the signature or until the termination of services and can be revoked by me at any time.

X Signature: _____ Date: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

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

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

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

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I will disclose PHI to any consultant only with your authorization. I may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

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

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

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

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

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

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

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

Deceased Patients. I may disclose PHI regarding deceased patients as mandated by state law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.

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

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

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

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

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

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

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

Research. PHI may only be disclosed after a special approval process.

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

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your

request in writing to me at my address, above:

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

COMPLAINTS

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

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Notice of Privacy Practices

Receipt and Acknowledgment of Notice

*Patient/Client Name:*_____

DOB: _____

SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Brynna Sibilla, LCSWs' Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact her at 503-280-1101.

_____

Signature of Patient/Client ***Date***

_____

Signature or Parent, Guardian or Personal Representative * ***Date***

_____

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

The effective date of this Notice is March 2010.

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