IRIS PSYCHOLOGICAL SERVICES

Iris Psychological Services
Lisa D. Hensley, Ph.D.
Licensed Psychologist, Texas License #36730

Client Information Form

Personal Information

Full Legal Name: _____

Preferred Name: _____

Date of Birth: ____/____/____ Age: _____ Preferred Pronouns: _____

Highest Level of Education Completed: _____
Current Occupation: _____

Demographic Information

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____ Text: ☐ Yes ☐ No

Email: _____

Address: _____

_____

_____

Emergency Contact Information

Contact Name: _____

Relationship to you: _____

Contact Home Phone: (____) _____-_____ Contact Cell Phone: (____) _____-_____

Primary Care Provider Name: _____

Provider Address: _____

Office Phone: (____) _____-_____

Permission to Consult with Primary Care Provider if necessary: ☐ Yes ☐ No

Medication List

List Any Medications you are currently taking. Please include prescription drugs, over the counter drugs, and recreational drugs. Include dosage, how often you take it, and reason.

Medication: _____ Dosage: _____ How Often: _____

Reason for Taking: _____

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Reason for Taking: _____

Medication: _____ Dosage: _____ How Often: _____

Reason for Taking: _____

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Reason for Taking: _____

Previous Psychological History

Have you had previous psychological care or counseling? ☐ Yes ☐ No

If yes, please list the name of the clinician(s), the months you saw them (i.e. Nov '06 – Nov '07), and give the nature of the care provided or difficulty at the time:

_____

_____

_____

_____

Have you ever been hospitalized for a psychological difficulty? ☐ Yes ☐ No

If yes, please list the place of hospitalization, the dates you were there (i.e. Nov '06 – Nov '07), and the nature of the care or difficulty being treated at the time:

_____

_____

_____

_____

Current Concerns

In your own words, please share the nature of your concerns you wish to address in therapy with me:

Any Additional Information or concerns you would like to share:

Referral Source (Optional)

How did you hear about Iris Psychological Services?

____ Referred by Another Therapist

____ Referred by a Friend or Family Member

____ Google Search

____ Professional Website

____ Other: _____

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AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

_____ _____
Name of Client Date of Birth

I,_____, hereby authorize Dr. Lisa Hensley, Ph.D. (hereinafter "Provider") to disclose/exchange mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to therapist's diagnosis, of the client listed above to:

_____ _____
Name Phone

_____ _____
Address Fax

_____
City State Zip

I am requesting this disclosure of information and records for the following purpose:

☐ At the request of the individual ☐ Other: _____

The specific uses and limitations of the types of health information to be released are as follows:
(Check all that apply)

☐ Treatment Coordination ☐ Diagnostic Refinement
☐ Treatment Planning ☐ Other: _____

Such disclosures shall be limited to the following specific types of information:

☐ Psychiatric diagnosis(es) ☐ Initial Treatment Plan
☐ Dates of Treatment ☐ Full Treatment Record
☐ Treatment Summary ☐ Other: _____

This authorization shall remain valid until:_____(not to exceed one year)

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has acted in reliance upon it. I also understand that such revocation must be in writing and received by Provider to be effective.

Provider shall not condition treatment upon my signing this authorization and I have the right to refuse to sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Texas law may protect such information.

_____ _____
Signature of Client Date

_____ _____
Signature of Legal Guardian, Relationship to Client Date

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Name _____ Phone _____

Address _____ Fax _____

City _____ State _____ Zip _____

I am requesting this disclosure of information and records for the following purpose:

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Informed Consent and Office Policies
For Relationship Therapy clients

Agreement for Psychotherapy

This document provides information about the relationship therapy process and the business policies for Dr. Lisa Hensley. Please take the time to read it carefully and ask about any items that seem unclear. By signing this form, you indicate that you agree to and understand the relationship therapy process and business policies between you and Dr. Hensley.

Relationship Therapy: Potential Benefits and Risks

If you have been in individual therapy before, you may already be familiar with the therapy process. In some ways, relationship therapy is similar, in that relationship partners may experience the following benefits: **(1)** increased insight into your patterns of feeling, thinking, behaving, and relating to your partner(s); and **(2)** communication, interaction, and coping skills that may help with current and future life challenges. Consistent attendance in therapy, openness on the part of the therapy clients, and work both in and outside of therapy sessions are necessary for improvement.

The major difference between individual therapy with relationship therapy, the client is the **relationship(s)** between/among partners, **not** the partners as individuals. Relationship therapy is about identifying interaction and communication patterns between/among partners. It is about helping people find new ways of relating to one another to increase safety, intimacy, and fulfillment of needs within your relationship(s). Each partner will be expected to honestly examine their own interaction and communication styles, to identify and express their own feelings, and to be willing to experiment with alternative methods of communicating and interacting. Each partner will be helped to further clarify their own values and their own level of commitment to the relationship. ***Please note****: Because the focus of the therapy is different from individual therapy, if one or more of you believes that individual therapy would be beneficial, and we are already engaged in relationship therapy, I will need to refer you to a different therapist for your individual therapy needs.*

As a therapist who is entrusted with information from both partners of a relationship, I have a **"no secrets"** policy. This means that I cannot promise to protect secrets of either partner from the other partner(s), especially if the secret is harmful or destructive to the process of the therapy itself or undermines the agreed upon intention of the therapy.

As with any therapy process, there are some potential risks in relationship therapy. We will be discussing topics that are often painful and distressing. It is sometimes awkward and difficult to learn new ways of relating to one another. If issues come up that have previously been avoided in the relationship, there may be a temporary increase in conflict. Perhaps most importantly, the outcome of relationship therapy is **not** necessarily the continuation of the relationship and/or increased satisfaction with one's relationship(s). Rather, the outcome may be increased clarity about a decision to dissolve the relationship(s), in which case, the focus of therapy may shift to finding ways to do this with as much care as possible.

Course of Treatment
Your first session/s will involve an evaluation of your needs. While evaluation is ongoing, the initial phase of evaluation will result in a discussion of your therapy goals and recommendations about how you might reach those goals.

I often (but not always) request individual sessions with each member of the relationship. Because I sometimes work with people who are in multi-partner relationships, I know that there is much diversity in terms of level of involvement among the partners. We will work together to determine who needs to be involved in therapy. Please be aware that one of the risks of not having all relevant parties involved in therapy is that important information and perspective may be unavailable to me, which will likely impact your therapy experience.

Following those individual sessions, we will meet as a group and develop a mutually agreed-upon treatment plan.

Should any of us determine that the type of treatment I can offer, or the mode of treatment (online) is not a good fit for you, or even if we find that I am not a good fit, I will share recommendations for the right type of treatment and provider.

Therapy may also involve recommendations or referrals to additional services that support your wellness (e.g. individual therapist, psychiatrist, physician). In some cases, these treatments are so vital and central to your recovery that your clinician is unable to ethically continue providing therapy without your concurrent treatment with these providers. Most often, however, these are recommendations not requirements.

Location of Services
I am currently offering services by **Teletherapy** only. Online therapy allows me to provide services to a broader geographic range of clients than in person services. I am a licensed psychologist in Texas (#36730) and may only provide services to clients within the state of Texas. Should I decide to offer in-person relationship therapy services later, I will inform you so that you may choose the location of services that meets your needs.

Technology How To
Most clients opt in to receive invitations to sessions via email and/or text. You will receive a reminder with a link to log in to the waiting room at our appointment time. I encourage clients to do a test log in prior to our appointment to make sure that everything is working well on their side. You can check that your mic, speakers, and video are working this way.

In relationship therapy, nonverbal interactions are as important as verbal interactions. Therefore, we should conduct relationship therapy sessions with partners in the same room, rather than in different rooms on different devices.

It takes a few seconds after you log into the waiting room for us to show up on each other's screens. That is normal. If it seems to be taking an inordinate amount of time, feel free to text, email, or call me so that we can troubleshoot together.

Please be sure to **EXIT** out of any programs that steal bandwidth prior to our sessions. **QUIT** (do not just minimize) skype, carbonite, google drive back up, or any other cloud backup service. Please ensure that no one in your home is streaming video or playing graphic heavy online video games as this will decrease our internet connection.

Tech issues are rare and usually quite easy to solve. Turning things off and back on again typically fixes most issues. If technical issues prevent us from continuing with the session via videoconference, we will switch to the telephone for the remainder of that session and attempt to resolve the technical issues for the next session.

Additional Pro-Tips for Online Therapy

- If others will be nearby while you are in therapy, ensure that you have adequate privacy prior to session. Psychotherapy is serious work. You do not want to be interrupted.
- Turn off notifications on your computer and phone once we are connected.
- Bring tissues. If you were in my office, I would provide them for you.
- You may be extra cozy because you are somewhere familiar to you and you may feel more casual because the work is online, and you are used to socializing that way. Remind yourself prior to the session that you are here to do the meaningful work of positive change.
- Research says that the connection between therapist and client is the primary determinant of therapeutic change. I want to make sure that we connect well over video so in our first session, I will share some tricks to make sure that we can look at each other, rather than the camera, when we talk. If it looks off to you, please let me know. Eye contact matters.

Emergency and Crisis Support

I do not provide 24-hour crisis services. If a life-threatening crisis should occur, contact a crisis hotline, call 911, or go to a hospital emergency room.

As an individual provider who is not in a group practice, I am generally in a therapy session during working hours and am unavailable outside of working hours. If it is likely that you may need crisis support, let us discuss this so that I can be sure you have the level of care you need.

You deserve support that matches your needs.

Iris Psychological Services
Lisa D. Hensley, Ph.D.
Licensed psychologist, Texas License #36730

Strengths and Limitations of Online Psychotherapy
Telephone, chat, and video sessions have some advantages over in-person psychotherapy. Many of my clients share with me that it is more convenient (no commute) and more comfortable (in their own space). Some clients share that they feel more able to share "deep" things because it is online rather than in person.

Online therapy is not for everyone.

If a client has a poor internet connection, a lack of privacy, or otherwise would simply be more comfortable meeting in person, it is better to connect them with a provider who offers that service. It is important to consider if this applies to you and may impact your therapeutic progress and select an in-person provider if so. In some clinical situations, such as crises or suicidal or homicidal thoughts, in-person treatment may be the most appropriate treatment choice.

Confidentiality
Information shared by a client during therapy sessions is confidential. This means I do not share your information with anyone except where legally or ethically bound to do so. Those circumstances are as follows:

- I am required to report suspicion of child abuse, neglect, or abandonment
- I am required to report suspicion of elder/vulnerable adult abuse, neglect, or exploitation
- I will share important and relevant information to protect a person to whom you appear to be an imminent and/or immediate physical threat
- I will share important and relevant information to protect you from imminent or immediate and/or immediate physical threat to yourself
- I may be required by Court Order to disclose treatment information.

Additionally, communication with me via any online or electronic means (e.g. email, text, video chat) is limited in security and thus your confidentiality may not be guaranteed. Please consider the limits of confidentiality in electronic communications outlined in more detail later.

In the event of an injury, illness, or other unexpected emergency situation that results in me becoming unavailable, your basic contact information (name and contact numbers or email) may be provided to a fellow clinician or associated professional. This will allow for your timely notification of appointment cancellations, as well as provide you with an opportunity to obtain further information regarding your continued care.

Considering all the above exclusions, if it is still appropriate, upon your request, I will release information to any agency/person you specify unless I conclude that releasing such information might be harmful in any way.

Because the "client" in this case is the **relationship**, please be aware that I cannot release records to any member of the relationship without the written permission of **all** participants.

Confidentiality and Social Interactions
Should we run into each other socially in person or online, I will never acknowledge working therapeutically with you. To protect our relationship, I cannot accept invitations to social events or social media requests. While you are welcome to visit my YouTube channel, professional social media pages, or website, I would discourage you from leaving messages there or "following/subscribing" simply to better protect your privacy and anonymity.

Confidentiality Policy in Emergencies
I do not provide 24-hour crisis services. However, should you enter a medical or psychological emergency during a session, I need to know your location so that I am able to get help to you. Please provide your legal name and the location from which you will be conducting our sessions.

Legal Name of Client Receiving Services: _____

Preferred Name of Client Receiving Services: _____

Legal Name of Client Receiving Services: _____

Preferred Name of Client Receiving Services: _____

Physical Location of Client Receiving Services:

_____

_____

_____

_____

Please sign below to indicate that you agree to share your location with me at the beginning of session should it be different from the one listed above.

_____

Signature Date

_____

Signature Date

Should you need physical or emotional assistance (e.g. approaching a psychological emergency but not at the threshold of needing to be hospitalized or feeling dizzy but not in need to an ambulance), I would like to be able to contact someone to assist you. Please name two emergency contacts, their relationship to you, their phone numbers, and email address. By signing below, you agree that I may, but am not required to, contact either of these people if I am concerned for your safety. In the case that I have dire concerns for your safety, I will do all that I can to protect you, including calling 911 or other emergency responders.

_____

Name, Relationship

_____

Phone number, Email

_____

Name, Relationship

_____

Phone number, Email

Confidentiality of Email, Chat, Cell Phone, Video, and Fax Communication
I use secure and encrypted video software for our sessions.

I use secure email, phone, and faxing systems. However, I want you to be aware that if you do not also use secure/encrypted programs on your side of the communication, the communications may not be secure. As a result, I start at a place of sharing as little as possible via these channels and will adapt to your comfort, with documentation, as we proceed. Security laws state that clients have the freedom to request or opt into less secure means of communication if they are aware of the risks, comfortable with them, and find it clinically helpful to do so.

I also want to acknowledge that while I regularly check in on the security of all our ways of communicating, swift advances in technology preclude my ability to be certain of our security. Just as I cannot guarantee a physical office space is not broken into, I also cannot guarantee the absolute security of our work online.

Please ensure that you too are doing your utmost to protect your privacy by considering who has access to your email, text messages, and so on before choosing online therapy. For example, I would discourage you from using your work email for our communications. Another way to protect your privacy is to fully exit all online counseling sessions and emails before leaving your computer.

Consultation:
I consult regularly with other professionals regarding my clients to provide the best care possible; however, the client's name or other identifying information is never disclosed. The clients' identity remains completely anonymous and confidentiality is fully maintained.

Dual Relationships
Not all dual relationships are unethical or avoidable. However sexual involvement between therapist and client is never part of the therapy process, nor are any other actions or dual relationship situations that might impair your clinician's objectivity, clinical judgment, or therapeutic effectiveness, nor that could be exploitative in nature.

Rates, Billing, and Payments
We have discussed and agreed upon the following rates:

50-minute Psychotherapy Sessions	$150.00
75-minute Psychotherapy Sessions	$200.00

Fees are due at the time of session unless we have made an agreement to the contrary. Ongoing psychotherapy typically occurs weekly for 50 minutes a session on a time and day agreed upon. Once the appointment is scheduled, you will be expected to pay for it unless you provide at least 24 hours' notice.

If you do not keep your account current, I may elect to refer your outstanding balance for collection to an outside collection agent and/or agency. If your account will be referred to an outside collection agency, the cost of that service will be added to your bill.

Other Professional Fees
The session charge of $150.00 will be used to calculate other professional services you may need. It will be broken down into 15-minute increments when services are provided for periods of time outside of those detailed above.

Other professional services may include:

- Report or letter writing to physicians, psychiatrists, etc.
- Telephone calls that last greater than 15 minutes
- Extended sessions
- Participation at meetings or phone consultations with other professionals (that you have authorized)
- Record or treatment summary preparation.

If you become involved in legal proceedings that require my assistance, you will be expected to pay for all qualified time, including planning and transportation costs. Due to the complicated nature and difficulty of legal involvement, the fee is $300 per hour.

Please take note of your agreement to avoid involving your clinician in legal proceedings (below).

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Contacting Your Clinician
I answer calls, texts, and emails as quickly as possible, but I am often not immediately available. Your call will be returned as soon as possible. If you are ever experiencing a life-threatening or harm-producing emergency, please call "911" or go to your nearest emergency room, and please contact me after you do this to keep yourself safe.

Methods of Communication
Given the limitations of security for electronic communication, I would like to know which of the following you are comfortable with. Please initial next to each method that you are comfortable using for administrative purposes like scheduling, invoicing, and collecting paperwork if not submitted through my client portal.

I, _____, consent to allow Dr. Lisa Hensley to contact me in the following ways for administrative purposes:

____Email

____Cell Phone ____Text via Cell Phone ____Voicemail via Cell Phone

____FAX

Please list your preferred email and phone number:

_____Email

_____Phone Number

Be aware that basic demographic details like your name, email, and location are considered Protected Health Information (PHI) as is anything clinical in nature like your diagnosis or clinical material. Please initial next to each item you consent to.

I, _____, consent to allow Dr. Lisa Hensley to use unsecured email, cell/VoIP phone text messaging, calls, faxes, or voicemail to transmit to me the following protected health information:

____ Information related to the scheduling of meetings or other appointments

____ Information related to billing and payment

____ Information that is clinical in nature (e.g. treatment summaries, diagnosis)

I, _____, have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

_____Signature

We will discuss the options you opted into in our meeting including the clinical utility of communicating in any of the ways mentioned above to decide together if we want to include them in your treatment.

Should we decide to share more than basic administrative materials electronically, we need to discuss it first in session so that we can weigh the pros and cons. The delivery of any electronic communication can be intercepted, misdirected, or delayed.

Decisions about this should be thoughtful, collaborative, and mutually acceptable.

Discharged from care
Psychotherapy is typically terminated when it becomes reasonably clear that the client no longer needs care. So that you can process the termination of the therapeutic relationship, a final appointment is helpful when ending therapy. This final appointment can be used to review your therapeutic growth, to plan next steps, and to process the termination of therapy.

If you do not show up to your appointment, and/or do not return calls or emails, it will be assumed that you are wanting to discontinue your therapeutic work and you will be discharged from care.

Both the therapist and the client have the right to end counseling at any time.

Litigation Limitation
Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.) neither you (client) nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the therapy records be requested.

Mediation and Arbitration
All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of you (the client) and I.

The cost of such mediation, if any, shall be split equally, unless otherwise agreed.

The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorney's fees. In the case or arbitration, the arbitrator will determine that sum.

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Agreement

By signing below, you acknowledge you have read the proceeding information, understand your rights as a client, and agree to psychotherapy services under these conditions. Additionally, your signature below indicates that you understand that I, Dr. Lisa Hensley, am an independent practitioner; therefore, the providers I contract with (e.g. my video software, my billing software, etc.) are not responsible for or involved in your care or treatment.

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

(add signatures as appropriate)

Please sign and date to signify that you have read and understand the Notice of Privacy Practices included with this paperwork by law:

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

(add signatures as appropriate)

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Lisa D. Hensley, Ph.D.
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NOTICE OF PRIVACY PRACTICES
Effective October 1, 2020

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

For more information about this notice, please contact Dr. Lisa Hensley, PH.D. at drhensley@irispsychologicalservices.com or (682) 438 -5195

This Notice of Privacy Practices describes how I may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice of Privacy Practices is **NOT** an authorization.

It also describes your rights to access and control your protected health information. "Protected health information" or "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health, or related mental health care services.

I am required to abide by the terms of this Notice of Privacy Practices. Upon your request, I will provide you with any revised Notice of Privacy Practices. Copies of this Notice are available from me by utilizing the contact information listed above.

I. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you which I have created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of the health care. I must provide you with this Notice about my privacy practices and such a notice must explain how, when, and why I will "use" and
"disclose" your PHI.

A "use" of PHI occurs when I share, examine, give, or otherwise divulge to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. I am legally required to follow the privacy practices described in this Notice; however, I reserve the right to change the terms of the Notice and my privacy policies at any time in accordance with HIPAA compliance and laws. Any changes will apply to PHI on file with me already.

II. HOW I MAY USE AND DISCLOSE YOUR PHI

I will use and disclose your PHI for many different reasons. I will need your prior written authorization for some of these uses or disclosures; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. **Uses and Disclosures Relating to Treatment, Payment or Health Care Operations Do Not Require Your Prior Written Consent**. I can use and disclose your PHI without your consent ONLY for the following reasons:

i. **For Treatment**. I can use your PHI within my practice to provide you with mental health treatment including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your case. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

ii. **To Obtain Payment for Treatment**. I can use your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

iii. **For Health Care Operations**. I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who have provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

iv. **For Patient Incapacitation or Emergency**. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent is not required if you need emergency treatment as long as I try to get your consent after treatment is rendered; or, if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. **Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization.** I can use and disclose your PHI without your consent or authorization for the following reasons:

i. **When federal, state, or local laws require disclosure**. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to governmental agencies and law enforcement personnel about victims of abuse or neglect.

ii. **When judicial or administrative proceedings require disclosure**. For example, I may have to use or disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or claim for workers' compensation benefits. I may also have to use or disclose your PHI in response to a subpoena.

iii. **When law enforcement requires disclosure**. For example, I may have to use or disclose your PHI in response to a search warrant.

iv. **When public health activities require disclosure**. For example, I may have to use or disclose your PHI to report to a governmental official an adverse reaction that you may have to a medication.

v. **When health oversight activities require disclosure**. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.

vi. **To avert a serious threat to health or safety**. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. Any such disclosures will only be made to someone able to prevent the threatening harm from occurring.

vii. **For specialized government functions**. For example, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations, if you are in the military.

viii. **To remind you about appointments and to inform you of health-related benefits or services**. For example, I may have to use or disclose your PHI to remind you about your appointments or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

C. **Certain Uses and Disclosures Require You to Have the Opportunity to Object**. Disclosures to family, friends, or others: I may provide your PHI to a family member, friend, or other person that you indicate that is involved in your care or the payment for your health care unless you object in whole or in part. The opportunity to consent may be obtained retroactively in an emergency.

D. **Other Uses and Disclosures Require Your Prior Written Authorization**. In any situation not described in sections III A, B, and C, above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I have not taken any action in reliance on such authorization) of your PHI by me.

III. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. **The Right to Request Restrictions on My Uses and Disclosures**. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members, friends, or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests but am not legally required to accept them. If I do accept your requests, I will put them in writing and will abide by them except in emergency situations. Be advised that you may not limit the uses and disclosures that I am legally required to make.

B. **The Right to Choose How I Send PHI to You.** You have the right to request that I send confidential information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. **The Right to Inspect and Receive a Copy of Your PHI.** In most cases, you have the right to inspect and receive a copy of the PHI that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I do not have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

D. **The Right to Receive a List of the Disclosures I Have Made.** You have the right to receive an Accounting of Disclosure listing the instances in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use; disclosures permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; and, disclosures made before April 14, 2003. I will respond to your request for an Accounting of Disclosure within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I may charge you a reasonable, cost-based fee for each additional request.

E. **The Right to Amend Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide, in writing, the request and your reason for the request. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request to amend your PHI, I will make the changes, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. **The Right to Receive a Paper Copy of This Notice.** You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

IV. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I have made about access to your PHI, you may file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S. W., Washington D. C. 20201. I will not take retaliatory action against you if you file a complaint about my privacy practices.

V. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES: Dr. Lisa Hensley, Ph.D . at drhensley@irispsychologicalservices.com or (682) 438 -5195

ACKNOWLEDGEMENT OF RECEIPT: NOTICE OF PRIVACY PRACTICES

I, _____, understand that by signing below I have read and understand Iris Psychological Services Notice of Privacy Practices as outlined above. I understand I have the right to ask questioned about this notice and to request a copy of the notice at any time. I also acknowledge, I have the right to refuse to sign this acknowledgement and for that refusal to be documented as part of my file.

_____ _____
PRINT Legal Name of Client Date

_____ _____
Signature of Client Date

_____ _____
Signature of Legal Guardian if Client is an Adolescent Date

E. **The Right to Amend Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide, in writing, the request and your reason for the request. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request to amend your PHI, I will make the changes, tell you that I have done it, and tell others that need to know about the change to your PHI.

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_____ _____
PRINT Legal Name of Client Date

_____ _____
Signature of Client Date

_____ _____
Signature of Legal Guardian if Client is an Adolescent Date