Registration Information
Please Print

_____
(Date)

Patient Name: Last_____First_____M.I._____

Address_____

City_____State_____Zip_____-_____

Home Phone( )_____Work Phone( )_____

Cell/Other Phone( )_____Email Address_____

Age_____ Date of Birth_____-_____-_____Female/Male _____Social Security #_____

Marital Status_____Employer/School_____

Referred by_____Email_____

Primary Care Physician/Address/Phone_____

In Case of Emergency call: Name_____Phone#( )_____

Person responsible for payment_____DOB:_____

-Relationship to patient_____Social Security #_____

-Employer of person responsible for payment_____

-Address of responsible party unless same as above_____

-City_____State_____Zip_____-_____

I am responsible for full & timely payment for services I request:_____
Signature of Responsible Party

Complete this part only if you plan to request reimbursement from insurance. Please discuss any parts of this that need clarification with your physician/therapist.

1. Check whether your insurance coverage requires pre-certification (the phone number should be on your card.
2. Ask a secretary to make a copy of your insurance card(s).
3. Primary insurance:_____PolicyHolder:_____DOB:_____
4. Secondary insurance:_____PolicyHolder:_____DOB:_____
5. I authorize my physician/therapist to release information about my condition and treatment to my medical insurance carrier for reimbursement. I am responsible for full and timely payment for services I request. It is my responsibility to contact the insurance carrier promptly when payment is delayed or miscalculated.

   Signature of responsible party_____ Date_____

6. I authorize the insurance company to reimburse my physician/therapist directly.

   Signature of responsible party_____Date_____

For office use only: C_____D_____E_____F_____

Patient will submit for insurance themselves _____Yes _____ No. Other arrangements agreed upon:

_____

Therapist Name:_____

Registration Information

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Please Print

Patient Name: (Last, First, Middle Initial) _____

1) Please list any medical conditions, include medications being taken for these conditions:

_____
_____
_____

2) Please list any allergies, include medications being taken for these conditions:

_____
_____
_____

3) Please list any previous psychiatric treatment:

Therapist's Name	Dates Seen	Medications (if any)

4) Please list any current psychiatric medications:

_____
_____
_____

5) I hereby give permission to you to notify my primary care physician of my contact with you (information listed of Page 1 of Registration Information Form).

Signed: _____ Date: _____
(Patient or Parent of Guardian)

NOTICE OF PRIVACY POLICY

PATIENT ACKNOWLEDGEMENT

CINCINNATI CENTER FOR PSYCHOTHERAPY & PSYCHOANALYSIS, INC.
3001 Highland Avenue
Cincinnati, OH 45219-2315

I, _____, hereby acknowledge that I was given a copy
(print name above)

of the Notice of Privacy Policy issued by Cincinnati Center for Psychotherapy & Psychoanalysis, Inc. on the date indicated below.

_____ _____
Signature Date

_____
(print name above)

Name of Patient (if other than above): _____

*Relationship to Patient:_____

_____ _____
Witness Signature Date

NOTICE OF PRIVACY POLICY

CINCINNATI CENTER FOR PSYCHOTHERAPY AND PSYCHOANALYSIS, INC.
3001 Highland Avenue
Cincinnati, OH 45219

(First Effective Date May 1, 2007; Revised September 23, 2013)

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.

If you have any questions about this Notice, please contact: Phyllis Donovan, Privacy Officer and Practice Administrator, at the address written above. The telephone number is (513) 961-8830.

I. OUR GENERAL DUTIES REGARDING YOUR MEDICAL INFORMATION

We receive, use and create medical information and records related to the care and services you receive at CINCINNATI CENTER FOR PSYCHOTHERAPY AND PSYCHOANALYSIS, INC. ("Practice"). We need such information to provide you with quality care, to comply with certain legal requirements, and to carry out business functions of the Practice. We are required by law to maintain the privacy of your medical information (also known as "protected health information"). In other words, we must make sure that medical information that identifies you is kept private. We are committed to protecting your privacy rights, and will only use or disclose your medical information as permitted by law.

This Notice applies to all of the records of your care used or generated by this Practice and describes the different ways that we use and disclose your medical information. It also describes certain rights that you have with respect to your medical information. We are required by law to give you this Notice of our legal duties and privacy practices with respect to medical information about you.

We are required by law to abide by the terms of the Notice that is currently in effect. Please be aware that we may change the terms of this Notice at any time. We will post a copy of the current notice in the office waiting area. In addition, each time you visit our office for treatment, we will make a copy of the current notice in effect available to you upon your request.

II. USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

A. Frequent and Routine Uses and Disclosures for Treatment, Payment, Health Care Operations, and Administrative Purposes.

At your first face-to-face visit to our offices on or after June 11, 2007, we will use good faith efforts to obtain from you a written acknowledgment that you have received a copy of this Notice of Privacy Practices. After that, with a very few exceptions described below, applicable Ohio and Federal (HIPAA) laws permit us to use and disclose your medical information for treatment, payment and/or health care operations purposes and other routine uses, as described below.

(i) **No Consent Required:** The HIPAA Privacy Rules and Ohio law state that we are not required to obtain your consent to use/disclose your patient information for the following purpose(s):

(a) **Treatment** - We may use or disclose medical information about you to provide you with medical treatment or services. This means that we may share medical information about you with outside doctors, nurses, and other staff here at the Practice who are involved in taking care of you. It also means that we may disclose medical information about you to providers outside our office who are or may be involved in your medical care. For example, we may disclose medical information to another physician, a hospital, surgical center or other facility to which we may send you for procedures or follow-up care. When sharing your confidential information with other health professionals involved in your care and/or treatment, the Practice shall ensure that all persons receiving the information are informed about the confidential nature of the information being shared and agree to abide by the rules of confidentiality for Ohio mental health professionals.

(b) **Other Administrative Purposes**-We may also use and disclose medical information about you:

- If we needed to contact you to remind you of an appointment for treatment at the Practice (but this may be limited by your request for confidential communications, as described below);
- To tell you about or recommend possible treatment options or alternatives that may be of interest to you; and
- To tell you about health-related benefits or services that may be of interest to you.

However, we will continue our long-standing practice of obtaining such consent from you using our standard form.

(ii) **Consent Needed.** For the following uses and disclosures, we will obtain your consent as part of our routine office registration procedures. Please understand that if you do not consent to our use/disclosure of your medical information for these purposes, we may refuse to treat you. Also, once you give your consent, that consent is effective until you specifically revoke it.

(a) **Payment** - We may use or disclose medical information about you to your insurance company, a governmental payer or other responsible third party for the purpose of receiving payment for the medical treatment you have received. For example, we may tell your health plan about a medical treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also use your medical information for billing and collections purposes

(b) **Health Care Operations** - We also may use and disclose medical information about you for purposes of health care operations. These uses and disclosures are for the necessary business of the Practice, and they include such activities as education and training and quality improvement. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. For some of these health care operations purposes, we will share your medical information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the Practice. Whenever an arrangement between our Practice and a business associate involves the use or disclosure of your medical information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

(iii) **Exceptions** -- Ohio law gives certain types of medical information more stringent confidentiality protection. Because of the nature of our Practice, we do not have frequent occasion to access, use or disclose some of the following types of information. If we do use such information, however, our practices are as follows.

(a) **AIDS/HIV** -- For purposes other than patient treatment, public health and safety, organ procurement, accreditation or oversight review, and emergency exposures, we must obtain your specific authorization before we disclose information about HIV/AIDS status or testing results. Thus, for example, we must obtain specific authorization from you before releasing any such information about you for payment or health care operations purposes, but we do not have to do so for treatment purposes.

(b) **Mental Health Records** -- For records, reports and applications pertaining to persons who are or were hospitalized, or whose hospitalization has been sought, pursuant to a court order, disclosure is prohibited except where the information is disclosed pursuant to a court order, to the patient's family member involved in treatment, to the executor or administrator of a deceased patient's estate, to the Department of Mental Health for quality assurance purposes, or to the appropriate prosecuting attorney for commitment proceedings. Information on psychological/mental health matters from any other sources are not given such special protection and may be used or disclosed by the Practice for the general treatment, payment and health care operations purposes, as described above in Paragraph (i) of this Section A.

(c) **Mental Retardation/Developmental Disabilities** – The personal and medical records of all mentally retarded/developmentally disabled persons shall remain confidential, except that such records may be disclosed pursuant to court order and where the managing officer for institution records (appointed by the director of the Department of Mental Retardation and Developmental

Disabilities) believes that disclosure to a mental health facility is in the best interests of the patient. Further, the identity of an individual who requests programs or services offered through the Department of Mental Retardation and Development Disabilities shall not be disclosed unless approved by the county board, necessary for approval of a direct service contract, or necessary to ascertain that the county board's waiting lists for programs or services are being maintained in accordance with the law.

(d) **Drug and Alcohol Treatment** – Records pertaining to the identity, diagnosis, or treatment of any patient which are maintained in connection with any state-licensed drug treatment program shall be kept confidential, except that such record may be disclosed pursuant to a written release signed by the patient, to court or governmental personnel having responsibility for supervising a parolee or probationary patient ordered to rehabilitation in lieu of conviction, to qualified personnel for the purpose of conducting scientific research, management, financial audits, or program evaluation, or pursuant to court order.

B. Other Uses and Disclosures of Medical Information for which Patient Permission or Authorization is Not Necessary

We may use and disclose medical information without your express permission in the following situations:

(i) **Uses and Disclosures to Family and Friends** - We may disclose to your family member, or close personal friend involved with your medical care, medical information about you that is directly relevant to your family member or friend's involvement with your care or with the payment related to your care. In most instances, before we disclose any medical information about you to your family members or your friends, we will inform you of the disclosure and give you an opportunity to agree or object to the disclosure.

(ii) **Uses and Disclosures for Disaster Relief Purposes** - For the limited circumstances of disaster relief efforts, we may disclose medical information about you to your close family or friends, or to a public or private disaster relief entity for purposes of notifying your family and friends of your condition and location. If you are available and competent, prior to the disclosure we will give you an opportunity to agree or object to the disclosure to the extent that providing you with prior notice and an opportunity to restrict or object to the disclosure will not interfere with our ability to respond to the emergency situation.

(iii) **Uses and Disclosures Required by Law** - We may use or disclose medical information to the extent that such use or disclosure is required by federal, state, or local law and the use or disclosure complies with and is limited to the relevant requirements of such law;

(iv) **Uses and Disclosures for Public Health Activities** - We may use or disclose medical information about you for public health activities, such as to:

(a) a public health authority that is authorized by law to collect or receive information for the purposes of preventing or controlling disease, injury, or disability;

(b) or to a public health authority or other appropriate government entity authorized by law to receive reports of child abuse or neglect;

(c) an FDA agent or official to report reactions to medication or problems with products;

(d) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; or

(e) an employer, to evaluate whether the individual has a work-related illness.

(v) **Disclosures about Victims of Abuse, Neglect or Domestic Violence** - We may disclose medical information about you to a government authority, including a social service or protective agency if we reasonably believe a patient to be a victim of abuse, neglect, or domestic violence.

(vi) **Uses and Disclosures for Health Oversight Activities** - We may disclose or use medical information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; or licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

(vii) **Disclosures for Judicial and Administrative Proceedings** -We may disclose medical information about you in the course of any judicial or administrative proceeding with a valid court order or appropriate subpoena or discovery request, so long as we follow certain procedures required by Ohio or federal law.

(viii) **Disclosures for Law Enforcement Purposes** - We may disclose medical information if asked to do so by a law enforcement official, so long as we follow certain procedures required by Ohio or federal law.

(ix) **Uses and Disclosures to Coroners, Medical Examiners and Funeral Directors** - We may release medical information to a coroner or medical examiner for the purpose of identifying a deceased person, determining the cause of death, or other duties as authorized by law. We may also release medical information to funeral directors as necessary to carry out their duties.

(x) **Uses and Disclosures for Organ, Eye or Tissue Donation Purposes** - We may use or disclose medical information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye, or tissue donation and transplantation.

(xi) **Uses and Disclosures for Research Purposes** - We may use or disclose medical information about you for research purposes, if we follow a special approval process. This process evaluates a proposed research project and its use of medical information, specifically trying to balance the research needs with patients' needs for privacy of their medical information. If we do not complete this approval process, we will not use or disclose medical information for research without your Authorization.

(xii) **Uses and Disclosures to Avert a Serious Threat to Health or Safety** - We may use or disclose (and sometimes Ohio law requires us to use or disclose) medical information about you if we reasonably believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of you or any other person.

(xiii) **Uses and Disclosures for Specialized Government Functions** - We may use or disclose medical information of individuals who are Armed Forces personnel, to authorized federal officials for national security and intelligence purposes and for protection of the President of the United States or other heads of state. In some circumstances, we may use or disclose medical information about an inmate or individual that the correctional institution has lawful custody of.

(xiv) **Uses and Disclosures for Workers' Compensation** - We may disclose medical information as authorized by and to the extent necessary to comply with Ohio's laws relating to workers' compensation.

C. Uses and Disclosures With Your Authorization Only --

A use and disclosure of medical information for purposes not listed above in Sections A and B, including most marketing purposes, or any uses or disclosures of psychotherapy notes, will only be made with the your written Authorization. The Authorization form that we use complies with applicable laws. You may revoke this Authorization at any time by providing us with written notice of such revocation. Your revocation shall become effective immediately upon our receipt of such notice, except to the extent that we have already relied upon your previous Authorization.

D. Breach Notification --

In accordance with the newer HIPAA rules, in the event that we become aware of an impermissible use or disclosure of your medical information which constitutes a threat the security and privacy of your

information, we will timely notify you of the breach and advise you of steps that we are taking to resolve the problem, as well as steps that you may wish to take.

III. YOUR RIGHTS REGARDING PRIVATE MEDICAL INFORMATION

You have the following rights with respect to your own medical information.

A. Right to Request Restrictions

You have the right to request that we restrict the uses or disclosures of your medical information to carry out treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care, like a family member or friend. For example, you could ask that we not disclose or use information about a certain medical treatment you received. **In most cases, we are not required to agree to your request, however.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. Under new rules, however, we are now required to honor your request to restrict disclosures of your treatment-related information to health plans, but only if that information pertains solely to a service or item that you personally pay for ("out-of-pocket").

To request restrictions, you must make your request in writing to **Phyllis Donovan,** at the above address. In your request, you must tell us:

- what information you want to limit;
- whether you want to limit our use, disclosure, or both; and
- to whom you want the limits to apply, for example, disclosures to your spouse.

B. Right to Receive Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work. To request confidential communications, you must make your request in writing to **Phyllis Donovan,** at the above address. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

C. Right to Inspect and Copy Your Medical Information

You have the right to inspect and copy medical information that may be used to make decisions about your care. If you agree in advance, we may provide you with a summary or explanation of your medical information.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to **Phyllis Donovan,** at the above address. If you request a copy of the information, we may, as permitted by Ohio law, charge a fee for the costs of preparing a summary or explanation of your medical information or for the costs of copying, mailing, or other supplies associated with your request. The person listed above can also advise you about any fees that we will charge for copying the information that you have requested.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to certain medical information, in many instances you may request that the denial be reviewed.

D. Right to Amend Medical Information

You have the right to request an amendment of your medical information if you feel the information is incomplete or incorrect for as long as the information is maintained by the Practice. To request an amendment, your request must be made in writing and submitted to **Phyllis Donovan,** at the above address. If for some reason the Practice, in compliance with state and federal law, rejects your amendment, we shall permit you to submit to us a written statement of disagreement to be kept with your medical information. The Practice may reasonably limit the length of such statement of disagreement.

E. Right to Receive an Accounting of Certain Disclosures of Medical Information

You have the right to receive an accounting of some of the disclosures of your medical information made by the Practice in the six years prior to the date on which the accounting is requested. We DO NOT have to account for disclosures made:

- to carry out treatment, payment and health care operations;
- to you (or your legal representative);
- for the facility's directory or to persons involved in the individual's care;
- for national security or intelligence purposes;
- to correctional institutions or law enforcement officials;
- pursuant to your Authorization;
- for certain research purposes; or
- that occurred prior to the compliance date for the Practice.

To request this list or accounting of disclosures, you must submit your request in writing to Phyllis Donovan, at the above address. You have the right to one accounting of disclosures of your medical information in a twelve-month period free of charge. We may charge a reasonable fee for the costs associated with your request for any additional accountings within the same twelve-month period. You may modify or withdraw your additional accounting requests in order to reduce or avoid the fee.

IV. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with this Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Secretary of the Department of Health and Human Services, contact Medical Privacy, Complaint Division, Office of Civil Rights, United States Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201; Voice Hotline Number (800) 368-1019.

To file a complaint with the Practice, contact Phyllis Donovan, who is the Privacy Officer and Contact Person for the Practice, at the above address (telephone: (513) 961-8830). All complaints must be submitted in writing.

You will not be penalized in any way for filing a complaint.

NOTICE OF PRIVACY POLICY

PATIENT ACKNOWLEDGEMENT

CINCINNATI CENTER FOR PSYCHOTHERAPY & PSYCHOANALYSIS, INC.
3001 Highland Avenue
Cincinnati, OH 45219-2315

I, _____, hereby acknowledge that I was given a copy
(print name above)

of the Notice of Privacy Policy issued by Cincinnati Center for Psychotherapy & Psychoanalysis, Inc. on the date indicated below.

_____ _____
Signature Date

_____
(print name above)

Name of Patient (if other than above): _____

*Relationship to Patient:_____

_____ _____
Witness Signature Date