Scott Schlachter, L.I.S.W.
Child & Adult Therapist

23875 Commerce Park Road
Suite 160
Beachwood, Ohio 44122
Telephone: 216-464-5500
Fax: 216-378-8900

Privacy Consent – For the Use and Disclosure of Protected Health Information

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to Scott Schlachter, L.I.S.W. to use and disclose my protected health information for the purpose of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize this psychiatry practice, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include therapy, medication management, assessment of my condition and supportive care and services related to my mental health, drug and/or alcohol related condition. This may include (but not limited to) evaluation of my mental status, medication management, psychotherapy, diagnostic testing, therapeutic care, rehabilitative, counseling, assessment or review of physical status/function of the body and the prescribing of drugs, or other services required for your care. This consent includes contact and discussion with other health care professionals, such as social workers, psychologist or medical physicians for your care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to use for any practice operation needs as identified in the practice privacy notice. My medical recorded may include information about mental health concerns, drug or substance abuse, and HIV or AIDS related diagnosis.

Consent related to the Privacy Notice: I have had a chance to review The Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected healthy information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me service if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation does not take affect until the practice receives it.

Patient/Guardian _____ Date _____

Name Printed _____ If not patient, relationship _____

Copy of Practice Privacy Statement signed or initiated with patient/guardian on _____

Patient unable to sign privacy statement due to _____

Revocation:
I hereby revoke the consent give above:

Patient/Guardian _____ Date _____

Name Printed _____ If not patient, relationship _____

Consent for the assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Patient/Guardian _____ 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 IT CAREFULLY.

I. This is a formal notification by the government concerning the privacy policy of this practice. This practice has an obligation to maintain all medical information in the strictest of confidence. Our practice cannot release information without your written consent, including medical records, conversations, reminder calls, test results and other confidential issues. Patient information about health care is identified as "PHI" or protected health information. This new policy requires that you, the patient, identify at the time of registration with us specific information about the release of information. You can change this information at any time with either written notification or verbal notification, followed up in writing. Changes can only impact the care of information from that point in time forward.

II. Your protected health information (PHI) is a part of your medical care, and can be used or disclosed as follows.

- For your treatment in this practice and other locations under our immediate care for care needs. This may include any mental health assessment, psychotherapy, medication management, referral for services, diagnostic tests or treatment related to your medical care needs.
- For obtaining payment for treatment with your identified health care program. This would include any documentation related to this care, including assessment or progress notes. This would include eligibility verification, prior authorization and claim submission.
- For operations of this practice, such as enrolling with insurance programs, hospital privileges, accounting and compliance with federal and state laws and regulations.
- Appointment reminders and health related benefit services <u>only</u> with your consent indentified on the registration form.
- Disclosure to your family and friends concerning any related health care information with your consent on the registration form which can be modified at any time orally, followed by written consent.
- **Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that in the judgment of the physician requires information for care on your behalf.**

<u>Certain disclosures can be made without your consent, and they are as follows:</u>

- Disclosures required by the government or law enforcement agencies. An example would be victims of abuse.
- Information used for public health purposes, medical examiners or related to a person's death or for the health department for disease tracking.
- Information used for health care oversight, such as a site review by an insurance program.

III. <u>Your rights for your health information include:</u> The right to request limits on the uses and disclosure at registration or any time during your care. The right to choose how we send this information to you, including an alternate address. The right to see and obtain copies of your PHI but there may be copy and postage fees. The right to get a listing of who we have made disclosures to about your PHI. The right to correct your file through an amendment process if appropriate.

IV. This practice reserves the right to modify or change this Privacy Statement and process at any time. Revisions to the Notice will be available upon request by contacting the office. The changers will be effective retroactively to the initial date of the Privacy Notice. An updated Privacy Notice will be posted in the office within 60 days of the revision.

V. If you have a concern or complaint about how you protected health information is being used, from this time forward, you should first contact our Practice Administrator at our Business office to resolve your concerns or you may contact the Office of Civil Rights or the Ohio Medicare Carrier, GBA Palmettl.

Office of Civil Rights – Regional Manager
Department of Health & Human Services
233 N. Michigan Avenue, Suite 240
Chicago, Illinois 60601

Palmetto GBA
Part B Operations – HIPPA Complaisance Concern
P.O. Box 182957
Columbus, Ohio 43218-2957

Patient signature on receipt of Privacy Notice:_____ Date: _____
Patient ___ Unable to sign due to: _____
___ Refusal to Sign Date: _____