Harmony Mental Health Services of North West

Elia Gonzalez-Rodriguez, MD

1499 SE Tech Center Drive
Suite 190
Vancouver, WA 98683
Office: 360-773-6340/Fax: 360-326-2606

Today's Date: _____
Patient's Name: _____
Date of Birth: _____ SSN: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Work Phone: _____
Mobile: _____ E-mail address: _____
Where can we leave a message? _____

Sex: M F Employed: Y N Student: Y N
Marital Status: M S D W O Employer: _____

Emergency contact and number: _____

****

By signing this form, I certify that I do not have Oregon Health Plan, Washington Medicaid or Medicare. I am aware that patients with Medicare / Medicaid coverage should not submit reimbursement requests to Medicare /Medicaid for services provided.

Patient Signature _____ Date _____

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Referral Source / Primary Care Physician Notification

The undersigned hereby authorizes Elia Gonzalez-Rodriguez, MD to notify the referral source of the patient's contact with Elia Gonzalez-Rodriguez, MD. The undersigned also authorizes Elia Gonzalez- Rodriguez, MD to notify the primary care physician listed below to share diagnosis and treatment plan to insure integrated treatment.

Put your initials on the line for "yes, you may contact" or "no, you may not contact"

Initial: _____ Yes _____ No

Referral Source (name): _____

Address: _____

_____

Phone number: _____

Please enter the information of your primary care provider below:

Initial: _____ Yes _____ No

Provider Name: _____

Address: _____

_____

Phone number: _____

Harmony Mental Health Services NW
1499 Tech Center Place, Suite 190
Vancouver, WA 98660

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I, _____, authorize HARMONY MENTAL HEALTH SERVICES NW at the above address to:

Patient Name (Print) Physician Name (Print)
Dr. Elia Gonzalez-Rodriguez

MD check all that apply

☑ Receive my medical history information from the following physicians:
(name, address)_____

(name, address)_____

☑ Receive my treatment records from the following therapist:
Therapist (name, address)_____

☑ Release my treatment information to the health insurance company listed below, for billing purposes:
Insurance provider (name, address)_____

☑ Receive information from all HARMONY MENTAL HEALTH SERVICES NW therapists:
Therapist (name, address)_____

☑ Receive and Release my treatment information and medical history to/from:
_____

_____

This information is for the following purposes (any other use is prohibited): _____

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that any action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during the treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIS (AIDS) or related illnesses. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_

_____ _____ _____
Patient Signature Patient Name (Print) Date

_____ _____ _____
Witness Signature Witness Name (Print) Date

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
3. Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable	☐ 0	☐ 1	☐ 2	☐ 3
7. Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐
Somewhat difficult ☐
Very difficult ☐
Extremely difficult ☐

Scoring

Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐

HARMONY
MENTAL HEALTH
SERVICES OF NW

Patient Self-Pay Agreement

You have registered as a private pay patient. This means that at the time of service you will be paying by cash, check, or debit/credit card. Due to this cash payment, you are receiving a discount. **We will not bill insurance** for services provided under this arrangement. No forms will be produced now, or in the future, for you or us to submit for insurance billing.

☐ I understand that I will be responsible for all charges related to the services provided to me by Pacific Phoenix Psychiatry/ TMS Services of Vancouver

☐ I understand that the charges presented to me are due **in full** on the day of service, unless arrangements have been made with the Billing Manager in advance.

SERVICE FEES:

- New Patient Evaluation: $425.00
- 15 minutes Brief Medication Management Appointment $170.00
- 25 minutes Expanded Medication Management /Therapy Appointment $225.00
- 45 minutes Detailed Medication Managment / Therapy Appointment $300.00
- 60 minutes Comprehensive Medication Management / Therapy Appointment $325.00
- Telephone / Video Appointments same as above
- Complex prior authorization or documentation completion, such as letters, forms completion requiring greater then 15 minutes of time will incur a $50.00 fees
- Missed appointments or late cancellation, with less then 2 business days notice will incur a $75.00 fees
- Sending Medical Records Handling Fees $ 35.00 for first 50 pages and 10 cents for each additional page thereafter.

I have read and fully understand the above self-pay rates and I agree to waive insurance billing and pay my balance owed at the time of check-in. I also understand by signing this acknowledgment that I will be responsible to pay for the services rendered to me and/or my dependent.

Responsible Party Name: _____ Relationship to Patient:_____

Signature: _____ Date: _____

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HARMONY
MENTAL HEALTH
SERVICES OF NW

Pre-Authorized Use of Credit/Debit Card

I, _____, authorize Harmony Mental Health Services of NW to keep my debit/credit card on file and charge for treatment services performed and to pay late cancellation or missed appointments fees.

I understand that it is my responsibility to confirm my insurance coverage and benefits prior to treatment. If my insurance applies any charges to my annual deductible or coinsurance, I understand that payment is still due and will be paid at the time the services are rendered.

I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

I understand that this form is valid for one year unless I cancel the authorization through written notice to the healthcare provider.

Patient Name: _____.

Signature: _____ Date: _____

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HARMONY
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Credit/Debit Card on File

The information provided will be discarded according to HIPPA standards as soon as it has been entered into the payment system.

_____

Patient Name

_____

Cardholder Name

_____

Cardholder Address

_____

City State Zip

_____

Debit/Credit Card Number CVV Expiration Date

_____

Cardholder Signature Date

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Prescription Drug Policy*

A comprehensive psychiatric evaluation with Dr. Gonzalez-Rodriguez will be required in order to receive a prescription for medication. Patients will be scheduled for follow-up medication management sessions to assure the best continuity of care. In order to provide the best ongoing care, we ask that our patients be aware of the following:

- **Any lost or stolen schedule II or IV prescriptions will not be replaced or re-written.**
- If you miss or cancel an appointment, it is at the physician's discretion to write a prescription for enough medication to last only until the next appointment.
- Please note: We do not mail prescriptions to patients or release prescriptions to 3rd party courier/delivery services.
- Medication changes will only be addressed during scheduled appointment times. If you are having side effects or urgent issues with the medication you are taking, this can be addressed over the phone with our support staff. After hours issues will need to be directed to urgent care or emergency facilities.
- All requests for 90-day prescriptions will only be written during scheduled appointments. Dr. Gonzalez-Rodriguez is unable to provide 90-day prescriptions for controlled substances such as stimulants and benzodiazepines.
- Prescriptions will not be refilled on weekends, holidays or after 12:00 pm on Friday. In addition, when you leave a message on our voicemail, please leave a phone number where you can be easily reached during office hours. Due to the high number of patient messages left every day, it is not possible for us to repeatedly return phone calls.

Print name: _____ Signature: _____

Witness: _____ Date: _____

*Policies and procedures are subject to change

PROVIDER ONLY

_____ Patient received copy of medication policy (please initial)

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Patient's Name: _____ Date: _____

SSN: - -

DOB: _____ Age: _____

Person completing this form: ☐ Patient or Other (give name): _____

What kind of help are you seeking? _____

Length of time symptoms: _____

SYMPTOM CHECK LIST: Please circle (use blank space to add items not listed)

□ Agitated	□ desperate	□ distracted	□ impaired performance
□ Fearful	□ overly tired	□ see things	□ obsessive/compulsive
□ Cry often	□ hear voices	□ suspicious	□ anxiety attacks
□ Hopeless	□ rapid speech	□ aggressive	□ avoidance of people
□ Withdrawn	□ anger/aggression	□ racing thoughts	□ headaches
□ Chest pain	□ irritable	□ appetite increase	□ indecisive
□ Mood swings	□ anxious	□ appetite decrease	□ sexual difficulties
□ Homicidal	□ depressed	□ helpless	□ self-harm thoughts/actions
□ Restless/on edge	□ confused	□ feeling "out of control"	□ guilt
□ Worry a lot	□ sad	□ personality changes	□ can't concentrate

SLEEP CHANGES? DESCRIBE: _____
_____

Energy Level: □ Tire easily □ Average energy □ High energy

DESCRIBE CURRENT STRESSORS: _____
_____

TREATMENT HISTORY: (CHECK ALL PRIOR Psychiatric/Psychological Treatment or Counseling)

Please identify when/where treated or who provided the following treatment:

□ None □ Inpatient Care: _____
□ Individual OP Therapy: _____
□ Family Therapy/Marital: _____
□ Partial/Day Hospital: _____
□ Medication Management: _____

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CHEMICAL ABUSE/DEPENDENCY HISTORY

Have you ever felt you should cut down on your drinking? □ NO □ YES

Have people annoyed you by criticizing your drinking? □ NO □ YES

Have you ever felt bad or guilty about your drinking? □ NO □ YES

Have you ever had a drink first thing in the morning to get rid of a hangover? □ NO □ YES

Is there a history of alcohol, marijuana, street drugs, or medication abuse/dependence? □ NO □ YES

If YES please explain: _____

Drug abused	Age at Onset	Dose/Amount	How Often	Last Used

Do you smoke? □ NO □ YES If yes, how much? _____ Trying to Quit? □ NO □ YES
Amount of caffeine consumed in a day: _____
Has there been exposure to toxic substances? □ NO □ YES _____

FAMILY HISTORY

Describe current home living arrangements, including who is living in your home with you:

□ Parents □ Spouse/Significant other □ Children □ Group Home □ Nursing home/Assisted Living

Has there been exposure to abusive behavior(s)? □ NO □ YES If yes, answer the following:

Current exposure? □ NO □ YES Past exposure? If so, when? _____
Who was the abuser? _____ Type of abuse: □ Physical □ Sexual □ Verbal
Did it occur: □ within the family □ outside the family?

Have any other family members sought or received mental health treatment? □ NO □ YES

Relationship: _____

Type of Problem/Care Needed: _____
_____

Is there a family history of alcohol or drug abuse/dependency? □ NO □ YES

If yes, please describe: _____

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MEDICAL HISTORY

Family Physician: Name: _____ Phone: _____
Date of your last complete physical exam? _____ Problems? _____
Accidents/Surgeries: _____

MEDICATIONS CURENTLY IN USE: (Prescribed or over-the-counter) □ None Used

Medication	Dosage	How Taken	Last Used

Psychiatric medications taken in the past:

_____
_____
_____
_____
_____

Medication allergies: _____

Other allergies: _____

Review of Systems

VISUAL
□ No Problem □ State Problem: _____

HEARING
□ No Problem □ State Problem: _____

RESPIRATORY
□ No Problem □ Asthma □ Hay Fever □ Congestion □ Short of Breath
□ Emphysema □ Wheezing □ Tuberculosis □ Sputum production □ Cough up blood

CARDIOVASCULAR
□ No Problem □ High blood pressure □ Low blood pressure □ Chest pain
□ Palpitations □ Prior heart attack □ Fainting episodes

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EXCRETORY
□ No Problem □ Urinary infections □ Bladder infections □ Incontinence of __ Urine __ Stool
□ Excessive night urination

NEUROLOGICAL
□ No problem □ Seizures □ Frequent headaches □ Migraines ☐ Cluster headaches □ Dizziness
□ Tremors □ Memory problems □ One-Sided body Weakness □ Pins and Needles Sensations
□ Past history of head injuries □ Loss of consciousness □ Meningitis

REPRODUCTIVE
Sexual orientation (is helpful to your therapy) □ Heterosexual □ Homosexual □ Bisexual
□ HIV+ □ Genital herpes □ Sexually transmitted diseases □ High risk for HIV/AIDS
□ Sexual worries □ Birth control issues

ENDOCRINE
□ No Problem □ Diabetes □ Hypoglycemia □ Thyroid dysfunction □ Edema or Swelling

GASTROINTESTINAL
□ No Problem □ abdominal pain □ frequent nausea □ frequent vomiting □ frequent diarrhea
□ frequent constipation
Weight □ Loss □ Gain Amount? _____ Appetite □ Poor □ Ravenous

MUSKULOSKELETAL
□ No Problem □ Muscle impairment/tenderness □ Joint pain □Back pain

CANCER Describe (type & treatment): _____
_____
_____

EDUCATION-OCCUPATION-COMMUNITY BACKGROUND

Highest level of education
□ BA or BS Degree □ High School Diploma □ Elementary education, level completed
□ GED □ Master's Degree □ Technical Degree □ Doctoral Degree

Have you been told you have learning difficulties/impairments? □ NO □YES

If yes, please describe: _____

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What community resources do you need or use? (I.e. social groups, clubs, self-help groups, community, church and social services): _____

_____

What or on whom do you rely on in times of stress? _____

_____

Patient currently is: □ Employed Full-Time □ Employed Part-Time □ Disabled □ Unemployed

□ Student: □ Full-time □ Part-time □ Retired, Retirement date: _____

Are you a Veteran of Military Service? □NO □ YES

If yes, what branch of service and describe and related problems: _____

_____

_____

Religious/Cultural Background:

□Protestant □Catholic □Jewish □Other (specify): _____

How significant a role does religion play in your life?

□Very important □Somewhat important □Minor importance □Not important

Your cultural/ethnic background: _____

Are there any cultural/spiritual/ethnic needs which might impact treatment or that you want us to know about? □ Yes □ No

If yes, please explain: _____

_____

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RISK ASSESSMENT

	Past	Present
Have you ever had thoughts of hurting yourself?	_____	_____
Have you ever had thoughts of committing suicide?	_____	_____
Have you ever had a plan to commit suicide?	_____	_____
Have you made threats to kill yourself?	_____	_____
Have you ever made a suicide attempt?	_____	_____
Have you ever mutilated yourself?	_____	_____
Have you ever had thoughts of harming someone?	_____	_____
Have you ever had plans to harm someone?	_____	_____
Have you ever attempted to harm someone?	_____	
Have you made any threats to harm someone?	_____	

Signature _____ Date _____

Physician-patient email communication template consent form

Physician information

Name: Elia Gonzalez-Rodriguez, MD

Address: 1499 SE Tech Center Place, Suite 190, Vancouver, WA 98683

Email: eliagonzalesrodriguezmd@gmail.com

Risks of using email

The physician offers patients the opportunity to communicate by email. Transmitting patient information poses several risks of which the patient should be aware. The patient should not agree to communicate with the physician via email without understanding and accepting these risks. The risks include, but are not limited to, the following:

- The privacy and security of email communication cannot be guaranteed.
- Employers and online services may have a legal right to inspect and keep emails that pass through their system.
- Email is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email once it has been sent.
- Emails can introduce viruses into a computer system, and potentially damage or disrupt the computer.
- Email can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of the physician or the patient. Email senders can easily misaddress an email, resulting in it being sent to many unintended and unknown recipients.
- Email is indelible. Even after the sender and recipient have deleted their copies of the email, back-up copies may exist on a computer or in cyberspace.
- Use of email to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Email can be used as evidence in court.
- The physician uses encryption software as a security mechanism for email communications.

The patient:

- Agrees to and will comply with the use of encryption software.
- Chooses not to use encryption software when communicating with the physician, with the full understanding that this increases the risk of violation of the patient's privacy.

Conditions of using email

The physician will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, the physician cannot guarantee the security and confidentiality of email communication. Thus, patients must consent to the use of email for patient information. Consent to the use of email includes agreement with the following conditions:

- Emails to or from the patient concerning diagnosis or treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those emails.
- The physician may forward emails internally to the physician's staff and to those involved, as necessary, for diagnosis, treatment, reimbursement, healthcare operations, and other handling. The physician will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- Although the physician will endeavour to read and respond promptly to an email from the patient, **the physician cannot guarantee that any particular email will be read and responded to within any particular period of time. Thus, the patient should not use email for medical emergencies or other time-sensitive matters.**

- Email communication is not an appropriate substitute for clinical examinations. The patient is responsible for following up on the physician's email and for scheduling appointments where warranted.
- If the patient's email requires or invites a response from the physician and the patient has not received a response within a reasonable time period it is the patient's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.
- The patient should not use email for communication regarding sensitive medical information, such as sexually transmitted disease, AIDS/HIV, mental health, developmental disability, or substance abuse. Similarly, the physician will not discuss such matters over email.
- The patient is responsible for informing the physician of any types of information the patient does not want to be sent by email, in addition to those set out in the bullet above. Such information that the patient does not want communicated over email includes:

  _____

  _____

  _____

  _____

The patient can add to or modify this list at any time by notifying the physician in writing.

- The physician is not responsible for information loss due to technical failures associated with the patient's email software or internet service provider

Instructions for communication by email

To communicate by email, the patient shall:

- Limit or avoid using an employer's or other third party's computer.
- Inform the physician of any changes in the patient's email address.
- Include in the email: the category of the communication in the email's subject line, for routing purposes (e.g., 'prescription renewal'); and the name of the patient in the body of the email.
- Review the email to make sure it is clear and that all relevant information is provided before sending to the physician.
- Inform the physician when the patient receives an email from the physician.
- Take precautions to preserve the confidentiality of emails, such as using screen savers and safeguarding computer passwords.
- Withdraw consent only by email or written communication to the physician.
- **Should the patient require immediate assistance, or if the patient's condition appears serious or rapidly worsens, the patient should not rely on email.** Rather, the patient should call the physician's office for consultation or an appointment, visit the physician's office or take other measures as appropriate.

Patient acknowledgment and agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the physician and me, and consent to the conditions outlined herein, as well as any other instructions that the physician may impose to communicate with patients by email. I acknowledge the physician's right to, upon the provision of written notice, withdraw the option of communicating through email. Any questions I may have had were answered.

Patient name: _____

Patient address: _____

Patient email: _____

Patient signature _____ Date _____

Witness signature _____ Date

Notice of Privacy Practices and Policies, *effective Oct, 1st, 2016*

AS REQUIRED BY FEDERAL LEGISLATION, THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice applies to all of the paper and electronic records of your care maintained by Elia Gonzalez-Rodriguez, MD, whether created by Dr. Gonzalez-Rodriguez, office personnel or records acquired from outside resources such as other clinicians involved in your care and laboratory reports.

I. Uses and Disclosures of Protected Health Information (PHI)

A. Permissible Uses and Disclosures without your written authorization.

The following categories describe ways that I use and share your confidential information. Confidential information includes Protected Health Information ("PHI" - information that could be used to identify you). Not every use or disclosure in a category is listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

1. ROUTINE SITUATIONS

For Treatment. I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment to coordinate care to the extent they need to know the information.

For Payment. I may use and disclose PHI so that the treatment and services you receive at the practice may be billed and payment may be collected from you, an insurance company or a third party – including a collection agency if necessary. For example, I may give your health plan information about services you received at the practice so your health plan will reimburse you for the services. I may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. I may use and share PHI for administrative functions necessary to run my practice and promote quality care. For example, I may use your information or combine it with other patient information to review the effectiveness of my treatment and services, to evaluate my performance in caring for you, or to make decisions about additional services my practice should offer. Wherever it is practical, I may remove information that identifies you.

I may share information with business associates who provide services necessary to run my practice, such as transcription companies or billing services in the future (none currently). I will contractually bind these third parties to protect your information as I would. Also, I may permit your health plan or other providers to review records that contain information about you to assist them in improving the quality of service provided to you.

Communicating with You and Others Involved in Your Care. My practice may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. In certain situations, I may share information about you with a friend or family member of yours who is involved in your care or payment for your care unless you have requested that such disclosures not occur and I have agreed. Information disclosed will be directly relevant to such person's involvement with your care or payment related to your care. Whenever possible, this person will be identified by you. However, in emergencies or other situations in which you are unable to indicate your preference, I may need to share information about you with other individuals or organizations to coordinate your care or notify your family.

2. SPECIAL SITUATIONS

As Required By Law: I will disclose information about you when required to do so by federal, state or local law. For example, I may release information about you in response to a valid subpoena or for communicable disease reporting.

(1) Health Oversight Activities: including audits, investigations, inspections, and licensure.

(2) For Judicial or Administrative Proceedings: in response to a court order or other lawful processes.

(3) To Avert Serious Threat to your Health or Safety or the health or safety of others

(4) Public Health Risks: including but not limited to

To prevent or control disease, injury or disability;

To report child abuse or neglect;

To report adult and domestic abuse;

To report reactions to medications or problems with products;

To notify people of recalls of products they may be using;

To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

(5) Law Enforcement: In response to a court order, subpoena, warrant, summons or similar process;

To identify or locate a suspect, fugitive, material witness, or missing person;

If you are suspected to be a victim of a

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Harmony Mental Health Services of NW
1499 SE Tech Center Place, Suite 190
Phone: (360) 773-6340

crime, generally with your permission;

About a death we believe may be the result of criminal conduct;

About criminal conduct at the hospital; and,

In emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

(6) Worker's Compensation: If you file a worker's compensation

(7) In the event of Medical Emergency

(8) In the event of the client's death or disability, information may be released if the client's personal representative or the beneficiary of an insurance policy on the client's life signs a release authorizing disclosure.

B. Uses and DISCLOSURES THAT REQUIRE your written AUTHORIZATION

Uses and disclosures other than those described in Section IA above will be made only you're your written authorization. For example, you will need to sign an authorization form before we can send PHI to a school or your attorney. You may revoke any such authorization in writing at any time.

Psychotherapy notes are handled separately under HIPAA and have additional protections. Specifically, the regulations state that in most instances a practice must obtain an authorization for any use or disclosure of psychotherapy notes. No authorization is needed to carry out treatment, payment, or health care operations and the uses listed in routine situations. All other circumstances require a valid authorization from you for use and disclosure.

II. YOUR RIGHTS AS A PATIENT

A. Right to request restrictions on certain uses and disclosures. You have the right to request a restriction or limitation on the use and sharing of information about you for treatment, payment, or health care operations. You must request any such restriction in writing. I am not required to agree to any such restriction you may request.

B. Right to receive confidential communications. You have the right to request that my staff or I communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or at a post office box. To request confidential communications, you must make your request in writing.

C. Right to inspect and obtain copies. You have the right to review and obtain copies of information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy information that may be used to make decisions about you, you must submit your request in writing. You may be charged a fee for the costs of copying, mailing or other supplies associated with your request. Under limited circumstances, I may deny access to your records if I believe the information may be harmful to you or someone else. You have the right to appeal any denials. The appeal will be reviewed by a qualified individual other than myself. I will comply with the outcome of the review.

D. Right to amend confidential information. If you feel that the information I have about you is incorrect or incomplete, you may ask me to amend the information. Your request must be in writing submitted to me, and it must explain why the information should be amended. I may deny your request under certain circumstances.

E. Right to receive an accounting of disclosures of confidential information. Upon request, you may obtain an accounting of certain disclosures of PHI made about you in the last six years, subject to certain restrictions and limitations.

F. Right to receive notification of a breach. We are required to notify you if I discover a breach of your unsecured PHI, according to requirements under federal law.

MY PRACTICE'S DUTIES

In addition to your rights as a patient, my practice has duties to protect your confidential information and inform you of changes to protection measures. I am required by law to maintain the privacy of confidential information and provide you with notice of my legal duties and privacy practices with respect to such information. I am required to abide by the terms of this Notice currently in effect.

CHANGES TO THIS NOTICE

I reserve the right to revise or change provisions on this notice. I will make the new Notice provisions effective for all confidential information I maintain. If I change this Notice, I will post the revised notice in the waiting room. The Notice will contain the effective date on the top of first page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Department of Health and Human Services. All complaints must be submitted or verified in writing. You have specific rights under the Privacy Rule. You will not be penalized for filing a complaint.

PRIVACY OFFICER

I am the privacy officer for my practice. You may contact me with questions or comments at 360-773-6340 or by mail to Elia Gonzalez-Rodriguez, MD, 933 NE Vancouver Mall Dr, Suite 203, Vancouver, WA 98662.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I am required to provide you with a copy of this Notice and document your receipt. Please fill out an Acknowledgement of Receipt of Notice of Privacy after receiving this Notice. (See Below.)

Elia Gonzalez-Rodriguez, MD Harmony Mental
Health Services of NW
1499 SE Tech Center Place, Suite 190
Phone: (360) 773-6340

Acknowledgement of Receipt of Notice of Privacy Practices

In order to comply with HIPAA standards each practice must obtain a signed acknowledgement that each direct treatment patient has received its Notice of Privacy Practices or must document a good faith effort to provide the Notice and receive a written acknowledgement of receipt. This will allow practices to use or disclose confidential information (protected health information) for treatment, payment, or health care operations.

I have received a copy of the Notice of Privacy Practices from:

Elia Gonzalez-Rodriguez, MD Harmony
Mental Health Services of NW
1499 Tech Center Place, Suite 190
Vancouver, WA 98660

Patient Signature: _____ Date: _____

Patient Name _____