ENHANCEMENT CENTER
MENTAL & BEHAVIORAL HEALTH

Phone (505) 891-1583 • Fax (505) 891-1768
info@enhancement-center.com • Ecmentalhealth.com

Informed Consent for Treatment

Client/Patient Name _____

Date of Birth _____

1. I give my authorization and consent to receive diagnostic and treatment services from The Enhancement Center.
2. I understand that I have other choices in the community for receiving behavioral healthcare, but freely choose to continue to receive services from The Enhancement Center. I understand that I have the right to change providers at any time.
3. I have been given information regarding my rights and responsibilities as an Enhancement Center client.
4. I have been given the Notice of Privacy Practices of The Enhancement Center, which describes how medical information about me may be used and disclosed and how I can get access to this information.
5. The heart of a therapeutic relationship is the confidentiality between a client and therapist. However, there are limitations to that confidentiality of which you need to be aware. The therapist has an obligation to inform the appropriate persons if there is any indication that you might harm yourself or others. The law of the State of New Mexico requires all mental health professionals to report suspected cases of child abuse, including child sexual abuse, to the New Mexico Children, Youth and Families Department.
6. I have been given information regarding the cost of services from The Enhancement Center. I understand that I may be responsible to pay a co pay and that it is payable each time I receive treatment.
7. I understand that I may address any concerns or grievances with my therapist or any other representative of The Enhancement Center at any time. I understand that I may also contact the licensing board, which regulates my therapist's professional practice.
8. I am freely choosing to enter into treatment, and I understand that I may discontinue treatment at any time.
9. I have been given information about the advantages and disadvantages of the treatment recommended as well as other alternatives.
10. I authorize the release of any medical or other information necessary to process claims. I also request payment of governmental benefits either to The Enhancement Center or myself.
11. I authorize payment of medical benefits to The Enhancement Center for treatment services.
12. I have been given information about The Enhancement Center's policy on missed appointments.

CLIENT / MINOR / PARENT / GUARDIAN

If a minor, I have the legal capacity under applicable New Mexico law to apply for consent to such treatment and services mentioned in this form, without parental consent.

If a parent or guardian I do hereby state that I am the natural parent or legal guardian of the client; therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned in this form.

_____
Name of person signing

_____
Relationship to the Client

_____
Signature

_____
Date

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Photo Identification

Client/Patient Name _____

Date of Birth _____

Photo identification is now required to combat potential fraudulent services.

☐ I am providing my photo identification attached.

☐ I will provide my photo identification to my therapist upon my first appointment

_____
Name of person signing

_____
Relationship to the Client

_____
Signature

_____
Date

ENHANCEMENT CENTER
MENTAL & BEHAVIORAL HEALTH

Clients' Rights and Responsibilities

- You have a right to receive information about Enhancement Center services, therapists, treatment guidelines and your rights and responsibilities.
- You have a right to be treated with dignity and respect.
- You have a right to privacy and confidentiality.
- You have a right to participate with your therapist in making decisions about your treatment planning.
- You have a right to voice complaints about The Enhancement Center or the care provided to you.
- You have a right to make recommendations regarding these "Clients' Rights and Responsibilities".
- You have a responsibility to provide, to the extent possible, information that The Enhancement Center and its therapists need in order to care for you.
- You have a responsibility to follow the plans and instructions that you have agreed upon with your therapist.
- You have a responsibility to participate, as much as possible, in understanding your behavioral health problems and developing mutually agreed-upon treatment goals.

CLIENT / MINOR / PARENT / GUARDIAN

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If a parent or guardian I do hereby state that I am the natural parent or legal guardian of the client; therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned in this form.

_____
Name of person signing

_____
Relationship to the Client

_____
Signature

_____
Date

ENHANCEMENT CENTER
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Consent for Transmission of Protected Health Information by Non-Secure Means

Client/Patient Name _____

Date of Birth _____

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with anyone from The Enhancement Center there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with someone from The Enhancement Center
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you don't want to access these communications, please talk with your therapist from The Enhancement Center about ways to keep your communications safe and confidential.

I consent to allow the therapist and administrative staff from The Enhancement Center to use unsecured (check all that apply)
☐ e-mail
☐ mobile phone text messaging
☐ other _____

to transmit to me the following protected health information (check all that apply):
☐ Information related to the scheduling of meetings or other appointments
☐ Information related to billing and payment
☐ Completed forms, including forms that may contain sensitive, confidential information
☐ Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
☐ My health record, in part or in whole, or summaries of material from my health record
☐ Other information. Describe: _____

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.

CLIENT / MINOR / PARENT / GUARDIAN

If a minor, I have the legal capacity under applicable New Mexico law to apply for consent to such treatment and services mentioned in this form, without parental consent.

If a parent or guardian I do hereby state that I am the natural parent or legal guardian of the client; therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned in this form.

_____
Name of person signing

_____
Relationship to the Client

_____
Signature

_____
Date

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Advance Directives for Mental Health

Client/Patient Name _____

Date of Birth _____

The following Advance Directive for Mental Health Treatment Form may be used to create an individual instruction regarding mental health treatment. An individual may complete or modify all or any part of the form. The Mental Health Care Treatment Decisions Act governs the effect of this, or any other writing used to create an advance directive for mental health treatment.

A principal may designate a capable person eighteen years of age or older to act as an agent to make mental health treatment decisions. An alternative agent may also be designated to act as an agent if the original agent is unable or unwilling to act at any time. An appointment of an agent may be accomplished by using the form provided by Subsection E of this section.

An agent who has accepted the appointment in writing shall have authority to make decisions, in consultation with the primary health care professional, about mental health treatment on behalf of the principal only when the principal is certified to lack capacity and to require mental health treatment as provided by the Mental Health Care Treatment Decisions Act. These decisions shall be consistent with any wishes or instructions the principal has expressed in the instruction. If the wishes or instructions of the principal are not expressed, the agent shall act in what the agent believes to be the best interest of the principal. The agent may consent to evaluation for admission to inpatient mental health treatment on behalf of the principal if so authorized in the advance directive for mental health treatment.

An agent may renounce the agent's authority by giving notice to the principal. If a principal lacks capacity, the agent may renounce the agent's authority by giving notice to the named alternative agent, if any, or, if none, to the attending qualified health care professional or health care provider. The primary health care professional or health care provider shall note the withdrawal of the last-named agent as part of the principal's medical record.

☐ Yes I would like to complete the Advance Directives for Mental Health

☐ No I would prefer to decline to complete the Advance Directives for Mental Health at this time.

☐ No, I would prefer to complete this with the help of a mental health professional. (If so, we will notify your therapist to assist you with this.)

_____
Name of person signing

_____
Relationship to the Client

_____
Signature

_____
Date

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Coordination of Care Form

With your permission, this information will be forwarded to your healthcare provider

Practitioner/Provider Information		Client/Patient Information	
Provider Name		**Client/Patient Name**	
Phone		**Client/Patient DOB**	
Fax			

Check if Client/Patient Authorizes Release of Personal Information (PHI)

From (Therapist Name):	**To (Provider Name):**
Client/Patient's Signature:	**Date of Client/Patient's Signature:**

Expiration: I understand that I may cancel this authorization at any time by sending my healthcare provider(s) my cancellation notice in writing. I understand that my healthcare provider(s) may have already released records according to this authorization, prior to receiving my written notice to cancel. Unless cancelled, this authorization expires one year from the signature date.

Check if Client/Patient Does Not Authorize Release of PHI

I **DO NOT** authorize information about my physical and/or behavioral health treatment to be release.

Client/Patient's Signature:	**Date of Client/Patient's Signature:**

You are not required to share this information. Please check this box if the reason you are not releasing information is because you do not have a primary care provider: ☐ Thank you.

Information to Be Released

The only information this Coordination of Care Form authorizes for release is this one-page Notification of Treatment, including the information below. No additional records will be released without a signed authorization for Release of Information.

Health Care Information		Medications (per client report)	Dosages
Treatment Start Date:	**Medication Managed by:**	**1.**	
ICD-10/DSM-5 Diagnosis:		**2.**	
		3.	
Treatment Plan:		**4.**	
		5.	

Confidential Protected Health Information (PHI) enclosed. PHI is personal and sensitive information related to a person's healthcare. It is being delivered to you after appropriate authorization from the patient/member or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without additional patient/member consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

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Consent for Telehealth Treatment

I (name of patient or parent/guardian) _____, agree to participate in telehealth assessment and treatment. By signing this agreement I authorize video session(s) with my mental health professional at The Enhancement Center, PC.

I understand that I can withdraw my permission at any time. I understand that if I do not choose to participate in a telehealth session, no action will be taken against me that will cause a delay in my care and that I may still pursue in-person consultation.

I understand that as with any technology, telehealth has its limitations. There is no guarantee, therefore, that telehealth sessions will eliminate the need for me to see a therapist or other mental health provider in person.

I understand that medical records of the telehealth sessions will be kept by The Enhancement Center the same way in-person session medical records are kept, but that no copies of the video sessions themselves are kept in any form.

I have been given information about the benefits and limitations of telehealth sessions, including in cases of urgent and emergency behavioral health needs.

My therapist and I have discussed my options in regards to any potential emergency situation that might arise just prior to or during a telehealth session. In those cases I have been instructed to contact or go directly to the following emergency medical providers:

CLIENT / MINOR / PARENT / GUARDIAN

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If a parent or guardian I do hereby state that I am the natural parent or legal guardian of the client; therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned in this form.

_____
Name of person signing

_____
Relationship to the Client

_____
Signature

_____
Date

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MENTAL & BEHAVIORAL HEALTH

Client Telehealth Guide

Compliance Issues

- The primary technologies used by The Enhancement Center for providing telehealth services are HIPAA compliant. Most of the redundant technologies are also HIPAA compliant, with the exception of telephone use, which is used as a last resort should all redundant technologies fail.
- The therapy space used by the therapist is secure and compliant.
- Therapists are trained on how to maintain confidentiality for the telehealth sessions.
- Therapists are required to continue to seek ongoing training on the use of telehealth.
- Clients are provided information about how to maintain confidentiality on the client side of the session.
- The Enhancement Center has a signed Business Associates Agreement (BAA) with our technology providers to ensure the confidentiality and HIPAA compliance of the video technologies we use.
- Video sessions are not stored in any manner.
- The session is recorded in the mental health record of the client the same as any other in-person session, with an indication that the session was conducted by video.
- Therapists follow The Enhancement Center's "Procedures for Management of Urgent and Emergent Situations".
- Therapists will follow all other standards of practice associated with traditional face-to-face counseling.
- Therapists will verify the identity of the client at each telehealth session. Verification means can include the use of code words or phrases.
- No sessions will be conducted with children under the age of 14 without a parent or guardian present.

At the Time of Your Session

- Telehealth requires that the client have an active email address, internet connection and a technology device with a microphone and camera: desktop computer, lap top computer, tablet or smartphone.
- At your appointment time, the therapist will email you a link to that day's session.
- Upon opening the email, click on the link. The link will take you to the telehealth website and place you in a "virtual waiting room". A notification is then sent to your therapist that you are present for your session.
- The therapist will then click on your connection and both you and your therapist will appear on the camera.
- Should the internet connection be unclear, alternatives to conduct the session will be attempted by both the client and the therapist.
- During telehealth sessions, the therapist will work to ensure that:
  - Sessions are conducted in a private environment such as their business office or home office.
  - Sessions are conducted with minimal to no interruption.
  - Sessions are conducted in a manner that the client feels the therapist is attentive and engaged just as they would be in person.

ENHANCEMENT CENTER

MENTAL & BEHAVIORAL HEALTH

Credit Card Payment Authorization Form

This form is optional

Arrange to have your office visit charges automatically charged to your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started!

Here's How Automatic Payments Work:
You authorize your office visit charges to your credit card. Once we have received a remittance back from your health plan explaining what you owe you will be charged the amount you owe for each session. If you choose, a receipt for each payment will be emailed to you. You agree that no prior-notification will be made to you. Your therapist is contracted to work with The Enhancement Center, therefore you will see the charge on your credit card coming from The Enhancement Center.

Please complete the information below:

I _____ authorize **The Enhancement Center** to charge my credit card
(full name)

indicated below for payment of the charges for which I am responsible for each session.

Zip Code Associated with this card _____

Email address to send receipts _____

Phone number to contact me _____

Name of client/patient_____

Credit Card

Cardholder Name _____

Account Number _____

Exp. Date _____

Security Code _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify **The Enhancement Center P.C.** in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

ENHANCEMENT CENTER

MENTAL & BEHAVIORAL HEALTH

Financial Responsibility Agreement

Client/Patient Name _____

Date of Birth _____

The Enhancement Center is committed to providing high quality mental health services. In order to do so, **payment is expected at the time of service**. Our clients or their financial/legal guardian are responsible for all fees associated with the services provided. We participate in many healthcare plans and work to provide everyone with a clear understanding of their financial responsibility for services provided.

1. **I understand that I am responsible for paying the full amount of each therapy session**. The Enhancement Center accepts Visa, MasterCard, Discover, American Express and Health Savings Account cards as well as payments by check and debit cards. Payments may also be made in person, over the phone to the main office at (505) 891-1583 or online at our website www.enhancement-center.com.

2. **I understand that I may make a payment myself, use insurance, or use a combination of these two methods to pay**.

3. The Enhancement Center reserves a time slot especially for each client. **I understand that I am required to give 24 hours' notice of cancellation of a scheduled session.** Failure to cancel within this period will result in a charge for the session of $45 payable directly to the therapist.

4. If my insurance plan includes a co-pay, **I understand that I am responsible for paying the co-pay on the day of the session**.

- If the co-pay amount changes, I understand that I am responsible for paying the new amount for all sessions covered by the change.
- If, at any time, my insurance company denies coverage, I understand that I am responsible for the full amount of the session(s) not covered by the insurance.
- I understand that if I have an insurance policy with an annual deductible, I may be responsible for the full amount of the session(s) until that deductible is met and that payment will be due at the time of each session.
- I understand that if the insurance company sends payment for services directly to myself, that balance must be made to The Enhancement Center within 72 business hours of receipt.

5. **I understand that I am responsible for notifying The Enhancement Center immediately of any changes in my insurance**, including canceling a policy and/or plan changes. I also understand that I am responsible for paying all sessions according to those changes.

6. **I understand that it is my responsibility to set up a payment plan as soon as possible, in the event there are financial difficulties interfering with my ability to pay**. We will work with each client to create a suitable payment plan. The Enhancement Center expects that you adhere to the contract you establish and notify us if the payment contract would need to be renegotiated. We do utilize the services of a collection agency. I understand that The Enhancement Center will refer any balances over 90 days, not in a payment contract, to our collection agency and any fees associated with the collection agency, will be my responsibility.

7. **The Enhancement Center reserves the right to require payment for services to be made at or before the time of service for outstanding balances for two or more sessions**. I further understand that The Enhancement Center may refuse to see clients who have outstanding balances for two or more sessions, and who are not making regular payments on the balance.

8. **The parent/guardian is responsible for payment of services rendered to your dependents account**. I understand that it is the policy of The Enhancement Center that in circumstances where the parents share legal custody that both parents shall be responsible for the payment of services provided their child. I agree to accept that responsibility for such payments.

_____

I have read, understand, and agree to comply with The Enhancement Center Financial Responsibility Agreement outlined above. I understand that I am responsible for all charges associated with my care, including but not limited to charges not covered by my insurance company, as well as applicable co-payments and deductibles. I acknowledge that these policies do not obligate The Enhancement Center to extend credit.

For Private Pay Services – I agree to pay the entire session fee(s) prior to services rendered. The Enhancement Center reserves the right to change our fees at any time.

Private Pay Fees

- $105 per session – (55 minutes or less)
- Other additional services as requested – $26.25 per 15 minutes (8-15 minutes)
- $120 for Equine-Assisted Psychotherapy sessions + $30 fee paid directly to the Equine Specialist per session.

For Health Plan Coverage Services - I understand that I am financially responsible for any applicable deductible, co-insurance or co-pays associated with my policy. I understand that if I am requesting to engage in Equine-Assisted Psychotherapy that I will be responsible for paying the Equine Specialist a fee of $30 per session. I understand that my insurance plan may have negotiated specific rates for services rendered and I would be responsible for the cost my specific insurance has identified, provided my insurance covers the service. Should services be denied, I understand that I am responsible for all fees associated with my account and my care. I understand that my plan may have certain restrictions with regard to yearly visit limits, and services covered and understand that I am fully responsible for ensuring my insurance has the information they need to provide coverage for the claim.

CLIENT / MINOR / PARENT / GUARDIAN

If a minor, I have the legal capacity under applicable New Mexico law to apply for consent to such treatment and services mentioned in this form, without parental consent.

If a parent or guardian I do hereby state that I am the natural parent or legal guardian of the client; therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned in this form.

_____
Name of person signing

_____
Relationship to the Client

_____
Signature

_____
Date

ENHANCEMENT CENTER

MENTAL & BEHAVIORAL HEALTH

Notice of Privacy Practices

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" (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 condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the therapist's practice.

Following are examples of the types of uses and disclosures of your PHI that the therapist's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your PHI. For example, we would disclose your PHI, as necessary, to a health insurance or Medicaid Program that provides care to you.

We will also disclose PHI to other health care providers who may be treating you or providing other health care type services to you. For example, an Occupational Therapist or psychiatrist may request consultation.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for therapy sessions or hours may require that your relevant PHI be disclosed to the health plan to obtain approval for treatment.

Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your PHI to student interns that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your therapist. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We will share your PHI with third party "business associates" that perform various activities (e.g., billing) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

We may use or disclose your demographic information and the dates that you received treatment from your therapist, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization
Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object
We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object
We may use or disclose your PHI in the following situations without your authorization. These situations include:

Required By Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the FDA to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

Your Rights

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that your therapist and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your therapist is not required to agree to a restriction that you may request. If a therapist believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your therapist does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your therapist. You may request a restriction by contacting our Privacy Contact.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your therapist amend your protected health information. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact, Jim Shotwell, Director at (505) 228-8536 or at enhancementcenter@msn.com for further information about the complaint process.

This notice was published and becomes effective on May 4, 2007.