Client Information – Child and Teen

Child's Name: _____ Birthday:_____ Today's Date:_____

Mother's/Guardian's Name:_____

Mother's/Guardian's Address: _____

Phone (C): _____ OK to leave message? ☐ Yes ☐ No

OK to text? (note: text is not secure) ☐ Yes ☐ No

Phone (H): _____ OK to leave message? ☐ Yes ☐ No

Phone (W): _____ OK to leave message? ☐ Yes ☐ No

Email: _____ OK to use? (email is not secure) ☐ Yes ☐ No

Father's/Guardian's Name:_____

Father's/Guardian's Address:_____

Phone (C): _____ OK to leave message? ☐ Yes ☐ No

OK to text? (note: text is not secure) ☐ Yes ☐ No

Phone (H): _____ OK to leave message? ☐ Yes ☐ No

Phone (W): _____ OK to leave message? ☐ Yes ☐ No

Email: _____ OK to use? (email is not secure) ☐ Yes ☐ No

Child's Religion / Spirituality (if any): _____ Ethnicity: _____

Current School and Grade: _____

Emergency Contact: _____Phone Number: _____

Referred by: _____

Main reason(s) for seeking help today:

_____

_____

_____

How long has your child had these problems or symptoms?

_____

_____

What have you tried?

_____

_____

Is your child adopted? ☐ Yes ☐ No Have they ever been in foster care? ☐ Yes ☐ No

Please check off any items that apply to your child:

Now	Past		Now	Past	
☐	☐	Failing grades	☐	☐	Mood swings
☐	☐	Sleep Problems	☐	☐	Excess energy
☐	☐	Feeling depressed	☐	☐	Racing thoughts
☐	☐	Unable to enjoy life	☐	☐	Impulsive behavior
☐	☐	Weight loss/gain	☐	☐	Recurring unwanted thoughts
☐	☐	Eating problems	☐	☐	Recurring unwanted behaviors
☐	☐	Cutting/self-injury	☐	☐	Defiant
☐	☐	Thoughts of suicide	☐	☐	Plans for suicide
☐	☐	Suicide attempt	☐	☐	Sexual/gender identity question
☐	☐	Poor concentration	☐	☐	Anxiety
☐	☐	Relationship problems	☐	☐	Panic attacks
☐	☐	Hearing voices	☐	☐	Explosive anger
☐	☐	Visual hallucinations	☐	☐	Violent behavior
☐	☐	Suspicion/distrust	☐	☐	Traumatic loss/separations
☐	☐	Disturbed sleep	☐	☐	Victim of bullying
☐	☐	Physically abused	☐	☐	Neglected
☐	☐	Emotionally abused	☐	☐	Sexually abused
☐	☐	Memory lapses	☐	☐	Behavior problems at school
☐	☐	Other _____			

MEDICAL INFORMATION

Date of Child's Last Medical Check-Up: _____Pediatrician:_____

Your child's health: Excellent Good Poor

Your child's diet: Excellent Good Needs Improvement

Your child's sleep: Excellent Good Poor

Does your child drink caffeine? ☐ Yes ☐ No How many caffeinated drinks per day? _____

Is your child physically active? ☐ Yes ☐ No How many days per week? _____

Does your child smoke? ☐ Yes ☐ No Does your child vape?` ☐ Yes ☐ No

Does your child use alcohol? ☐Yes ☐No Other drugs? ☐Yes ☐No _____

Please list any serious/chronic medical conditions or allergies:_____

_____

Has your child had any serious accidents, head injuries, or seizures? ☐ Yes ☐No

Has your child ever been hospitalized for psychiatric reasons? ☐ Yes ☐No

Has your child ever taken medications for depression, anxiety, sleep, ADHD, etc.? ☐ Yes ☐No

If yes, when and what medication? _____

_____

Who prescribed the medication? _____

Any problems during pregnancy/birth or developmental delays? ☐ Yes ☐No If yes, please explain:

_____

_____

Family Information

	Name	Age	Where living?	Quality of relationship with child?
Mother/Guardian				
Father/Guardian				
Step-mother				
Step-father				
Siblings				
Step-siblings				
Others at Home				

Please list any family members who have had emotional, psychological or neurological problems, including problems with drugs, alcohol or other addictions:

Relation to child: _____Problem: _____

Relation to child: _____ Problem: _____

Relation to child: _____ Problem: _____

Relation to child: _____ Problem: _____

OTHER

Why did you decide to seek help *at this time*? _____

_____

_____

_____

_____

Who else is helping you with this problem? _____

_____

_____

What previous counseling / therapy has your child had? _____

_____

_____

_____

How are you hoping therapy will help your child? _____

_____

_____

_____

_____

How long are you hoping it will take? _____

Is there anything else I should know that might be important in helping your child?

_____

_____

Consent to Treatment of a Minor
or Person Under Guardianship

I, _____, give permission for Tom Rogat, Psy.D.,
(print your name)
to provide psychological services for _____ who is my
(print minor's full name)
_____ .
(state relationship)

I grant permission for Tom Rogat, Psy.D., to provide and/or seek medical treatment for my child in the event of any emergency that occurs on the premises.

_____
Name of parent or legal guardian

_____
Signature of parent or legal guardian

_____
Date

Tom Rogat, Psy.D., M.B.A.
Rogat Psychological Services, LLC
www.drtomrogat.com

3601 Green Road, Suite 201
Beachwood, OH 44122
(216) 355-1970

Client Information and Agreement - Minors

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our meeting. When you sign this document, it will represent an agreement between us.

Psychological Services
Psychotherapy varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. I may use a variety of methods to help you, including psychodynamic, cognitive-behavioral, and solution-focused therapies, among others. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and outside of them.

Psychotherapy has been shown to have significant benefits for the majority of people who commit themselves to it. It often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, it can be hard work and there is no guaranteed outcome. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness.

Our first few sessions will involve an evaluation of your needs. At the end of the evaluation, I will give you my impression of your situation and plan for how to best move forward. You should evaluate this information along with the level of comfort you feel about working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Meetings
I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-minute session per week at a time we agree on, although some sessions may be longer or held more frequently.

Arriving Late
Please call and let me know if you are running more than 5 minutes late for an appointment. If you are more than 15 minutes late for an appointment and I have not heard from you, I will assume that you are not keeping the appointment and I may or may not be available for the remainder of your session time. Missed appointments are charged at full fee.

Fees, Billing and Payment
The fee for a 45-minute session is $170. The fee for a 60-minute session is $230. Please note that payment is due at the time of service, unless otherwise agreed upon by both parties in writing. If you would like to make a different arrangement, please let me know. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. I accept cash, checks, and credit cards. There is a 3% fee applied to credit card payments. Please make any cash payments for the exact amount due. A fee of $15 is charged for returned checks.

In addition to weekly appointments, I charge at the rate of $230 per hour for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations totaling more than 15 minutes in a week, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional

time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $450 per hour for preparation and attendance at any legal proceeding.

Cancellations
Once an appointment is scheduled, you will be expected to pay for it unless you provide at least **two full business days** (including over weekends and national holidays) of advance notice of cancellation. For example, a 2pm Thursday appointment needs to be cancelled by 2pm Tuesday, and a 2pm Monday appointment needs to be cancelled by the 2pm on the previous Thursday. However, I will try to find another time to reschedule an appointment during the same week. If I can do so, there will not be a fee for cancellations with less than two full business days of advance notice. Please note that if a late cancellation is re-scheduled and that appointment is also missed or cancelled with less than two full business days of notice **there will be a charge for both session times**.

Regular weekly appointment times are reserved for clients who maintain consistent attendance.

Insurance
I am not a member of any health care panel. For all insurance plans that specify network providers, I will be considered out of network. I recommend contacting your insurance company to find out what portion of the fees they will cover for an out of network provider if you would like to seek partial reimbursement for the services. You will be responsible for balances not covered by insurance and for obtaining necessary authorizations and re-certifications. I can bill your insurance company directly once each month or you can submit claims on your own. If you would like me to file for you, please ask for an Insurance Profile Form or contact Elaine Weiss at (330) 425-4072. You are responsible for maintaining your own records regarding insurance practices. This includes, but is not limited to, dates for filing panel reviews, pre-certifications and number of visits allowed.

You should be aware that your insurance company may require you to authorize me to provide them with a clinical diagnosis, and they may ask that I provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases) for reimbursement. This information will become part of the insurance company files and will probably be stored in a computer.
Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

Contacting Me
Calls, emails and texts are monitored from 7am to 5pm Monday through Thursday and Friday from 9am to 4pm. I make every effort to return all messages on the same business day you contact me, but sometimes I may respond the next day. On weekends and holidays I check voicemail once each day. Please note that **only emergency calls are answered outside of business hours. Text messages and emails are not checked outside of business hours and should not be used for emergencies.** If you will be difficult to reach, please inform me of times when you will be available.

If you are unable to reach me and feel that you can't safely wait for me to return your call, contact your family physician or the nearest emergency room and ask for the mental health professional on call. The Cuyahoga County Community Mental Health Board and National Suicide Prevention Hotline also provide 24-hour suicide and crisis hotlines, and there is also a 24-hour nationwide Crisis Text Line:

Cleveland Area:	(216) 623-6888
National Hotline:	(800) 273-8255
Crisis Text Line:	text HOME to 741741

If you are having a **life threatening emergency, call 911 immediately**.

If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Emails, cell phones, and computers: It is very important to be aware that computers and unencrypted email and texts can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails and texts are vulnerable to such unauthorized access since servers or communication companies may have unlimited and direct access to all emails and texts that go through them. While data on my laptop is protected, emails that you send probably are not. It is always a possibility that texts and email can be sent erroneously to the wrong address and computers. Please notify me if you decide to avoid or limit, in any way, the use of email, texts, cell phones calls, or phone messages. If you communicate confidential or private information via unencrypted email, texts or via phone messages, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate on such matters. Please do not use texts, email, or voice mail for emergencies.

Confidentiality
In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. However, there are a few exceptions.

- If I know or suspect that a child, or developmentally disabled or physically impaired person under 21 years of age, is being abused or neglected I am required to immediately report to the appropriate authorities.

- If I have reasonable cause to believe that a dependent or elderly adult is being abused, neglected or exploited, I must immediately report to the appropriate authorities.

- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

- If a patient presents a threat of bodily harm to another, I am required to take steps to protect/warn potential victims. This can include notifying the potential victim(s) and contacting the police. I also may need to seek hospitalization for the patient.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you.

Minors
If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you are in harm's way for any reason. In this case, I will notify them of my concern. Before giving them any information I will discuss the matter with you, if possible, and do my best to handle any objections you may have.

Access to Records
As outlined in the accompanying HIPAA Notice of Privacy Practices, you have certain rights to your Health Insurance Portability and Accountability Act (HIPAA) – defined Protected Health Information. In addition, you are entitled to review or receive any other records that I keep, unless I believe that seeing them would be emotionally damaging. I generally recommend that we review records together. Alternately, I may be able to prepare a summary for you or to send them to a mental health professional of your choice who can review them with you.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____
Child's name (please print)

_____ _____
Parent/Guardian's name(s) (please print) Date

_____ _____
Parent/Guardian's Signature(S) Date

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you,_____, and this office. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here:_____.

When we examine, diagnose, treat, or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read it before you sign this Consent Form.

If you do not sign this form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future, we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want excluded in writing. Although we try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information form that time on, but we may already have used or shared some of your information and cannot change that. There are certain laws that force us to comply with sharing information, such as, but not limited to, insurance companies needing certain information to consider a claim, courts, etc.

_____ _____

Signature of client Date

_____ _____

Signature of client Date

Tom Rogat, Psy.D., M.B.A.
Rogat Psychological Services, LLC
www.drtomrogat.com

3601 Green Road, Suite 201
Beachwood, OH 44122
(216) 355-1970

NOTICE OF PRIVACY PRACTICES

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

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

Uses and Disclosures for Treatment, Payment, and Health Care Operations
I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:
PHI: refers to information in your health record that could identify you.
Treatment, Payment and Health Care Operations:
- Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
- Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
Use: applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
Disclosure: applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization
I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

Uses and Disclosures with Neither Consent nor Authorization
I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If, in my professional capacity, I know or suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, I am required by law to immediately report that knowledge or suspicion to the Ohio Public Children Services Agency, or a municipal or county peace officer.

Dependent/Vulnerable Adult Abuse: If I have reasonable cause to believe that a dependent or vulnerable adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or

exploitation, I am required by law to immediately report such belief to the County Department of Job and Family Services.
Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release this information without written authorization from you or your persona or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety: If I believe that you pose a clear and substantial risk of imminent serious harm to yourself or another person, I may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to me an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and I believe you have the intent and ability to carry out the threat, then I am required by law to take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s).

Worker's Compensation: If you file a worker's compensation claim, I may be required to give your mental health information to relevant parties and officials.

Other: When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

Breach Notification
1. When the Practice becomes aware of or suspects a breach, as defined in Section 1 of the breach notification Overview (see appendix), the Practice will conduct a Risk Assessment, as outlined in Section 2.A of the Overview. The Practice will keep a written record of that Risk Assessment.
2. Unless the Practice determines that there is a low probability that PHI has been compromised, the Practice will give notice of the breach as described in Sections 2.B and 2.C of the breach notification Overview.
3. The risk assessment can be done by a business associate if it was involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in its control, the Practice will provide any required notice to patients and HHS.
4. After any breach, particularly one that requires notice, the Practice will re-assess its privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches.

Patient's Rights and Psychologist's Duties
Patient's Rights:
Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request process.

Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy: You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Right to Be Notified if There is a Breach of Your Unsecured PHI**.** You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Right to restrict disclosures: You have the right to restrict certain disclosures of Protected Health Information (PHI) to a health plan if you pay out-of-pocket in full for the healthcare service.

Psychologist's Duties:
I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I must have you sign an authorization before I can release your PHI for any uses and disclosures not described in the Privacy Notice.
I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will notify you in writing by mail.

Questions and Complaints
If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me. If you believe that your privacy rights have been violated and wish to file a complaint with me/my office, you may send your written complaint to me at 3601 Green Road, Suite, 314, Beachwood, OH, 44118. I can also help you contact the Ohio Board of Psychology if your complaint is not resolved to your satisfaction.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

Effective Date, Restrictions and Changes to Privacy Policy
This notice will go into effect on 9/23/13.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by writing in the mail.

Appendix

Breach Notification: What is a Breach?
The HITECH Act added a requirement to HIPAA that psychologists (and other covered entities) must give notice to patients and to HHS if they discover that "unsecured" Protected Health Information (PHI) has been breached. A "breach" is defined as the acquisition, access, use or disclosure of PHI in violation of the HIPAA Privacy Rule. Examples of a breach include: stolen or improperly accessed PHI; PHI inadvertently sent to the wrong provider; and unauthorized viewing of PHI by an employee in your ractice. PHI is "unsecured" if it is not encrypted to government standards. A use or disclosure of PHI that violates the Privacy Rule is *presumed* to be a breach unless you demonstrate that there is a "low probability that PHI has been compromised." That demonstration is done through the risk assessment described next.

If a Breach is Known or Suspected
A. Risk Assessment
The first step if you discover or suspect a breach is to conduct the required risk assessment. (You must take this step even if the breached PHI was secured through encryption.) The risk assessment considers the following four factors to determine if PHI has been compromised:
1) **The nature and extent of PHI involved**. For example, does the breached PHI provide patient names, or other information enabling an unauthorized user to determine the patient's identity?
2) **To whom the PHI may have been disclosed.** This refers to the unauthorized person who used the PHI or to whom the disclosure was made. That person could be an outside thief or hacker, or a knowledgeable insider who inappropriately accessed patient records.
3) **Whether the PHI was actually acquired or viewed.** Factors 2 and 3 can be illustrated by comparing two scenarios. In both scenarios, your office has been broken into and your locked file cabinet with paper patient records has been pried open. In Scenario A, you suspect that a burglar was simply looking for valuables because cash and other valuables (but no patient files) have been taken. In Scenario B, you suspect the husband of a patient in the midst of a contentious divorce because no valuables have been taken; only the wife's file appears to have been opened, and the husband has a history of similar extreme behavior. In Scenario A, the likelihood that a burglar was rummaging through files seeking only valuables, indicates a relatively low risk that PHI was actually viewed. In Scenario B, the identity of the suspected "breacher" suggests a very high risk that the wife/patient's PHI was viewed and compromised.
4) **The extent to which the risk to the PHI has been mitigated.** For example, if you send the wrong patient's PHI to a psychologist colleague for consultation, it should be easy to obtain written confirmation from the colleague that they will properly delete or destroy the PHI on the wrong patient. By contrast, if your laptop has been stolen you have little assurance that the thief will respect your patient's confidentiality.

If the risk assessment fails to demonstrate that there is a low probability that the PHI has been compromised, breach notification is required — **if** the PHI was unsecured.

Insurance Information

*This form is **only** required if you would like to have your sessions billed for potential out-of-network benefits.*

Client Name: _____Date of birth _____

Card-holder's Name: _____ Card-holder's date of birth_____

Card-holder's address:_____

_____

Insurance ID Number: _____

Group Number:_____

Insurance Company:_____

Insurance Company Phone Number:_____

Insurance Company's Address:_____

_____

_____

Billing questions? Feel free to speak with Dr. Rogat or call Elaine Weiss at (330) 425-4072.

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