PRE-INTAKE FILLABLE FORM

<table>
<tr><td colspan="2">Name</td><td>Date</td></tr>
<tr><td colspan="2">Street</td><td>Suite/Apt. #</td></tr>
<tr><td>City</td><td>State</td><td>ZIP Code</td></tr>
<tr><td>Phone (primary)
Is it ok to leave messages at this number?</td><td colspan="2">Phone (work)
Is it ok to leave messages at this number?</td></tr>
<tr><td>Age</td><td colspan="2">Date of Birth (Month/Day/Year)</td></tr>
<tr><td colspan="3">Email Address</td></tr>
<tr><td>Name of person you live with</td><td colspan="2">Relationship</td></tr>
<tr><td colspan="2">Emergency Contact Name</td><td>Relationship</td></tr>
<tr><td colspan="2">Street</td><td>Suite/Apt. #</td></tr>
<tr><td>City</td><td>State</td><td>ZIP Code</td></tr>
<tr><td>Phone (primary)</td><td colspan="2">Phone (work)</td></tr>
</table>

Name/Relationship of person filling out this form (if not patient)
Name of referring or responsible party (if applicable)
PHARMACY INFORMATION: **Name** **Location** **Phone**
PRIMARY CARE CLINICIAN: **Name** **Location** **Phone**
<u>INSURANCE INFORMATION</u>: **Insured's Name** **Date of Birth** **Relationship to patient** **Address** **City** **State** **Zip Code** **Employer**

Demographics	**Marital Status**	**Work/School**
Race___________________ Gender_________________ Religion________________ Sexual Orientation______________ Age and DOB___________________	Single Married Separated Divorced Widow(er)	--------Name of School or Workplace --------________________________ Current Position/Grade ________________________ Highest Level Completed ________________________

Sherri Simpson Broadwater, M.D.
Healing For All, LLC
432 Georgia Avenue, Commercial Unit 100
Atlanta, Georgia 30312
Phone: 844-HEAL-ONE
Fax: 678-335-2480
www..healingforall.net

Treatment Policies and Care Agreement

Instituted March 21, 2018

Please read the following sections carefully, as they represent your agreement in this care contract. Your initials after each section and signature at the end indicate acceptance of these policies.

As a patient of Healing For All, LLC, you can expect to be:

- treated with consideration and respect
- be viewed as a unique and worthwhile individual with strengths as well as vulnerabilities
- have your experiences heard with compassion and non-judgment
- receive care in a comfortable and private setting
- receive care that is free from discrimination on any basis
- have appointments that start and end on time
- be educated about your condition and options for its treatment, including non-treatment, and be involved in all decisions about your care
- have any concerns and questions addressed in a timely manner
- have every aspect of your care remain strictly confidential, except when the doctor is required by law to do otherwise
- have any grievances or concerns responded to in a respectful and constructive manner
- have access to your medical record, if requested
- be fully informed about financial aspects of your care
- be able to designate a health advocate to help you with decision-making in your care
- be helped to find alternative care if you or the doctor feel that a different care arrangement is in your best interest

Office Hours and Appointments

Healing For ALL Office Policies

- New patient appointments are 60 minutes; Adult and child routine, follow-up visits for wellness/medication management are 30 minutes. Psychotherapy sessions are 45 to 55 minutes. New patient appointments can proceed only if the requested intake forms are completed and provided in advance of the appointment. I agree to be seen for all follow-up appointments by Dr. Broadwater's office or designated person at least every three months. At the beginning of our work together, we may meet every week to every month. If I my condition changes and I need to be seen sooner, I will call for an earlier appointment. ***Initial*** ______

Consent for Treatment

- All patients will be asked to sign a consent to treatment form.

- Parent or Guardian MUST be present at the time of any minor's appointment. Dr. Broadwater will not be able to make any changes to medication regimens without a parental consent of a minor. For minor patients, proper guardianship papers must be shown including foster, adoption and medical consent.
 Initial _______

Communication

- At this time, Dr. Broadwater's office manages all scheduling via telephone and communicates with patients on other matters via phone. Routine calls are generally returned on the next business day between 12-1 pm OR 6-9 pm Monday - Friday. Please allow at least 24-48 hours for non-urgent issues to be addressed via a call back from Dr. Broadwater's office staff or Dr. Broadwater. All or some of your information may go through the office staff and is confidential. Staff of Dr. Broadwater sign a confidentiality agreement. Dr. Broadwater allows for 10 minute phone calls. Any time after that will result in a $65.00 fee per 10 minutes. *I consent to doctor-patient communication via email at Dr. Broadwater's discretion. I understand that even when all reasonable security measures are employed, email cannot be guaranteed as entirely private and confidential, and that emails I send will be included as part of my medical chart.* In an emergency, or in the case of suicidal or violent thoughts, patients should call 911 or go to their local emergency room. Patients in emotional crisis may also call the Georgia Crisis Line at 800-715-4225 or go to mygcal.com for assistance. For urgent but non-life-threatening issues, patients may call Dr. Broadwater.

Urgent phone calls are returned within 12 hours. Non-urgent calls are addressed within 24-48 hours. Frequent after hour calls will result in more frequent appointments. If Dr. Broadwater calls back on her personal cell phone, this phone number is not to be used for any reason unless given instruction to do so. Please do not use this for call backs, appointments and or cancellations, texting or medication refills. Please do not give Dr. Broadwater's phone number out to anyone.
Initial ____

By signing you are agreeing to receive communication from Dr. Broadwater via email and texting.

Initial ______

Arrival, Cancellations and Missed Appointments

- *I will make every effort to arrive on time for my appointments. If I arrive late, I understand that I will be seen for the time remaining in the appointment but missed time cannot be made up. If I am 15 minutes late for a 30-minute visit, I understand I cannot be seen that day and will be rescheduled. When possible, if running late, I will notify my doctor by urgent phone call. I will provide 48 hours' notice of a cancellation or a reschedule request. Without provision of 48 hours' notice, I agree to pay the full appointment fee as outlined in the Financial Agreement.* Dr. Broadwater makes an exception to this policy only for women in labor or who have been admitted to the hospital. First-time patients who arrive 15 or more minutes late cannot be seen that day, and will be rescheduled. A no-show appointment will be billed for the total amount. Cancellations will ONLY be acknowledged via office telephone. Due to excessive weekend cancellations leaving slots we are unable to fill, a late cancellation fee will now be charged for any Monday cancellation NOT DONE BEFORE NOON on the Friday PRIOR to the weekend.
Initial _____

Disability Evaluations

- I do not provide one-time assessment for disability or disability insurance.
- I can only complete supportive documentation on your behalf for medical leave, excused absence from school, or other reasons if you have been my patient for **at least six (6) months** and I have been assessed a **minimum of 5 times** (including initial evaluation and routine follow up appointments) as well as managed your

psychiatric care during the applicable period of illness. This service is billed at our hourly rate. Completion of any paperwork is at the discretion of the physician.

Prescription Policies

- *I understand that my doctor will prescribe enough medication to last until the next recommended visit via phone calling to your pharmacy at this time. . I will track my current supply of medication and remaining refills. I will request prescription refills during my appointments.* Prescriptions may only be called in for patients who are current patients and whom maintain regularly scheduled appointments. If you have not been seen in 3 months or more your chart will be closed and your refill will not be filled. The responsibility for making a timely appointment request that ensures an adequate supply of medication is min*e. If I do not meet this responsibility, I agree to pay the fees for interim (between-visit) or urgent refills - $50.00 to replace a lost prescription, $50.00 for same day refills, $25.00 for next day refills, if my doctor judges such a refill to be medically necessary. Please allow for 5 days for a prescription refill to be addressed. Refill requests will only be honored in person and or telephone. Refill email and or texts to the office will not be honored. For your safety, medication refills will not be called in over the weekend. There may be a charge for telephone refills requested after business hours unless prior arrangements have been made in advance with your physician. Prescriptions for controlled substances such as sleep, anti-anxiety or ADHD medication will only be provided during appointments . I understand that while being prescribed a controlled substance, I will need to be seen monthly for the first several months, and then at least every 3 months once stable, without exception.* Dr. Broadwater subscribes to the Georgia and Texas State Prescription Drug Monitoring Programs to track patients' use of controlled substances. Lost stimulant prescriptions will require a police report in order for a new prescription to be given. Misrepresentation about or misuse of controlled substances may be cause for patient discharge. Dr. Broadwater does not prescribe BENZODIAZEPINES (VALIUM, XANAX, ATIVAN, KLONOPIN OR OTHERS.), NARCOTICS (CODEINE, MORPHINE, NORCO, OXYCONTIN OR OTHERS.) AND DOES NOT TREAT ADULT- ONSET ADHD WITH STIMULANTS (ADDERALL, CONCERTA, METHYLPHENIDATE, VYVANSE, OR OTHERS). *I understand and agree to these office policies regarding prescriptions and controlled substances.*
  Initial _____

Confidentiality and Release of Medical Records

- Your status as a patient and all information related to your care is treated confidentially. This office will NOT share or release health information about you to anyone, including your spouse/partner, family, or employer without your written consent. There are legal exceptions to this rule, which you can review with the doctor *including safety concerns. I have had all questions related to confidentiality satisfactorily answered. I agree to keep a current consent-to-release-information form on file with this office. I will supply my doctor with all prior mental health records and select physical health records that she requests. I agree to keep my doctor updated about changes in my health conditions and about medications being prescribed to me by other doctors. I understand I have the right not to share my medical records, but this may jeopardize my overall care and cause the termination of the doctor-patient relationship.* ***Initial*** ______

- I have read the HIPPA forms given to me by this office. ***Initial*** ______

- Prohibited contact with associated treatment team members may make it difficult for Dr. Broadwater to provide standard of care. If so, then transition to another clinician may be indicated. ***Initial*** _______

Health Habits

- Being honest with your doctor about your lifestyle habits allows for the best outcomes. *I agree to disclose to my doctor, at the onset of care and on an ongoing basis, my habits such as diet, exercise, smoking, internet use, shopping, gambling, sexuality, alcohol and other drug use, sleep habits, stress management and relationships. I understand that maximizing healthy habits and self-care is vital to my treatment.* ***Initial*** _____

Office Closure

- You will be given ample notice if Dr. Broadwater will be out of town resulting in closure of the office. Instruction of how to contact Dr. Broadwater if different from the standard policy will be recorded on the doctor's outgoing voicemail.
  Initial _____

Policy Concerning Children

- Do not leave your children unattended in the waiting room. Our office cannot watch them. If you bring a child to the appointment, but wish to speak to the doctor in private, bring someone with you to watch you child/children in the waiting room
  Initial ______

Alternatives to In-Person Appointments

- Dr. Broadwater offers appointments in a variety of ways - Dr. Broadwater's office(s), virtually, via telephone, or out of office accommodating her patients as best possible. I acknowledge that this is at the discretion of Dr. Broadwater. Alternative locations may result in higher fees. Virtual and or telephone appointments are at the discretion of Dr. Broadwater and are NOT routinely utilized for child/teen appointments. Out of office locations have geographic and time-of-day restrictions. Using an alternate modality is not always medically appropriate, and the doctor may decline to provide such a service and recommend an in-person appointment instead. *If I request a phone or virtual appointment, I agree to pay the full cost of the service. I also understand that even when all reasonable security measures are employed, these alternate modalities cannot be guaranteed as entirely secure and confidential.*
  Initial _____

Lab work

- I will obtain all ordered labs and tests, including fasting labs, within two weeks of receiving the order forms. Noncompliance with recommended laboratory monitoring to ensure your health while taking medication(s) will result in discharge from our practice. ***Initial*** ______

Social Media and Networking

- Psychiatric care works best when conducted in a confidential, safe, well-bounded setting. As a matter of policy, Dr. Broadwater does not interact with patients on personal social media or networking sites. ***Initial*** ______

Documents

- Documents and forms require 7-10 business days for completion. A fee will be charged for any forms/letters that need to be completed/written. Fee starts at $25.00 and increases in accordance with the amount of time spent preparing forms and/or letters. Fees must be paid PRIOR to release of completed documentation. The fee will be doubled for documents that need to be completed sooner than 7 business days from the date of the request. ***Initial*** ______

Medical Records

- Fees for Medical Records are as follows based on the State of Georgia:
  Search Fee : $25.00
  Pages 1 - 20 : $0.97 per page
  Pages 21 - 100 : $ 0.83 per page
  Pages 101+ : $0.66 per page
  Certification Fee : $9.70
  O.C.G.A. 31-33-3; Rates do no apply to disability applications.

- Fees for Medical Records are as follows based on the State of Texas:
  Hospital Fees
  Pages 1 - 10 : $45.74 flat fee
  Pages 11 - 60 : $1.54 per page
  Pages 61 - 400 : $0.76 per page
  Pages 401+ : $0.41 per page
  Postage : Actual cost of mailing

If records are stored on digital or electronic platform: Search Fee : $82.87
Postage : Actual cost of mailing
Texas Health & Safety Code §241.154

Please allow for 7-10 work days for medical records to obtained, confined and mailed out.
Initial ______

Patient Satisfaction and Grievances

- Dr. (Simpson) Broadwater has an unrestricted medical license (#MD67942 and M67933) in the States of Georgia and Texas. The doctor and her staff are strongly committed to patient satisfaction and to working together with patients to ensure they receive high-quality, compassionate medical care. To that end, patients are asked to discuss any concerns or dissatisfaction directly with Dr. Broadwater. *I agree that if I am dissatisfied with some aspect of my care, I will a) inform Dr. Broadwater in writing that I have a grievance and b) give her the opportunity to remediate it. If no such remedy is possible and I choose to terminate my care, I agree to do so in writing. I also agree that I will follow these steps before posting a negative review of the doctor or her practice in any public forum, and that if I do post a negative online review that I will do so in a constructive and respectful manner.* ***Initial*** ______

Guarantor's Signature ____
Date ____
Printed Name of Patient (Minor) ____
Printed Name of Guarantor (Adult Patient) ______________________________

Healing For All
Financial Agreement - Insurance and Workers' Compensation
Dr. Sherri Marie (Simpson) Broadwater
Board Certified Adult, Child and Adolescent Psychiatrist

Our clinical staff are providers on select insurance and managed care plans.

If we are a contracted provider for your insurance plan, we will bill the insurance directly. Payment of any applicable co-insurance, co-payment or deductible is due at the time services are rendered. If we do not have a contractual provider relationship with your insurance plan, full payment for services is due at the time services are provided.

I agree to pay my co-insurance, co-payment, or deductible before each appointment.Initial___________

Some services may not be covered by health insurance. Charges for uncovered services will be your responsibility. This may include charges for telephone consultations, written correspondence, or reports in connection with evaluation or treatment, and charges for appointments that are missed or canceled without at least 48 hours prior notification.

We will try to handle all insurance issues in order to save you that time, but the final responsibility for payment of charges for our services is yours. Every insurance policy varies with respect to the specific benefits and coverage provided. We will contact your insurance provider to learn of the benefits you have chosen and we will do our best to explain your insurance benefits to you. However, we encourage you to call your insurance company yourself to learn exactly what your mental health benefits are (they are often different from other medical benefits). When we call your insurance provider to verify your benefits, it is not uncommon that we are given erroneous, misleading, or contradictory information. Therefore, we cannot be responsible if the information we provide you is in error and your insurance ends up covering a smaller amount of your charges than you expect, or does not cover our services at all.

I agree to verify my mental health coverage and it is my responsibility to verify any insurance information provided to me by Healing For All, LLC. Initial___________

If your insurance policy changes, please call our office to inform us of your new policy and bring your insurance card with you to your next appointment. Most policies have a limit to how long after an appointment the service can be billed to the insurance. Therefore, if you fail to notify us of a change in your health insurance policy in a timely manner, you will be responsible for the entire amount of the charges not covered by insurance.

I agree to pay for any and all the amount of my appointment if it is not covered by insurance coverage.
Initial___________

I authorize the release of medical information necessary to process any of my insurance claims or workers compensation claims and I authorize payment of medical benefits directly to **Healing For All** for services rendered. Initial__________

If you are receiving workers' compensation, please inform us immediately if there are any changes including adjuster's information/address, fees or the terms of your workers' compensation.

I agree to inform Healing For All of any and all changes above. I am fully responsible for any outstanding payment owed to Healing For All in the event there is a lapse or end of my workers' compensation. Initial__________

If I fail to notify the office about my inability to keep a scheduled appointment at least 48 hours prior to such appointment, I agree to pay a **$75 no show fee.** Initial__________

Due to excessive weekend cancellations leaving slots unable to fill, a **$95 late cancellation fee** will now be charged for any Monday cancellation NOT DONE BEFORE NOON on the Friday PRIOR to the weekend. Initial__________

Upon arrival I understand that I will be asked to leave credit card information on file.

I, the undersigned, agree that regardless of any insurance coverage, I am financially responsible for all charges generated for this patient including appointment fees, late and no show fees, medical records, letters, speaking with collaborating clinicians, teachers, attorneys, or other.

I understand that unpaid balances over 30 days past due may carry a late fee equivalent to 1.5% per month of that outstanding balance. I understand that unpaid balances over 90 days past due may be referred to a collection agency.

Party Responsible for Payment
First and Last Name (if someone other than the patient, identify relationship to patient)

____

Email Address: ____
Physical Address: ____
Primary Phone: ____
Patient Name: ____

Signature: ______________________________ Date:____

Healing For ALL, LLC
HIPAA PRIVACY NOTICE
Effective April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

Introduction

We are required by law to maintain the privacy of "protected health information." "Protected health information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care. As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a copy of our most current privacy notice from our office.

Permitted Uses and Disclosures

We can use or disclose your protected health information for purposes of treatment, payment and health care operations.

- Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health-care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Therefore, the doctor may review your medical records to assess whether you have potentially complicating conditions like diabetes.
- Payment means activities we undertake to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, prior to providing health care services, we may need to provide to your insurance carrier (or other third party payor) information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the carrier or other third party payor for the services rendered to you, we can provide the carrier or other third party payor with information regarding your care if necessary to obtain payment.
- Health Care Operations mean the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what services are not needed, and whether certain new treatments are effective.

Disclosures Related To Communications With You Or Your Family
We 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 or relate specifically to your medical care through our office. For example, we may leave appointment reminders on your answering machine or with a family member or other person who may answer the telephone at the number that you have given us in order to contact you.

We may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the protected health information that is directly relevant to their involvement in your care.

We will allow your family and friends to act on your behalf to pick up prescriptions, medical supplies, X-rays, and similar forms of protected health information, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

Other Situations
Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
Military and Veterans. If you are a member of the Armed Forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report victim of abuse, neglect, or domestic violence
- To report reactions to medications
- To notify people of product, recalls, repairs or replacements
- 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

Health Oversight Activities. We may disclose medical information to federal or state agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. We may disclose protected health information to persons under the Food and Drug Administration's jurisdiction to track products or to conduct post-marketing surveillance.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in a response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.
Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process
- To identify or locate a suspect, fugitive, material witness, or missing person
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of a criminal conduct
- About criminal conduct on our premises
- 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

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.
Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.
Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
Disaster Relief. When permitted by law, we may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.

Your Rights

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request.
2. You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations.
3. Subject to payment of a reasonable copying charge as provided by state law, you have the right to inspect or obtain a copy of the protected health information contained in your medical and billing records and in any other practice records used by us to make decisions about you, except for:
    - Psychotherapy notes, which are notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record

- Information compiled in a reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.
- Protected health information involving laboratory tests when your access is required by law
- If you are a prison inmate and obtaining such information would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you
- If we obtained or created protected health information as part of a research study for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research
- Your protected health information is contained in records kept by a federal agency or contractor when your access is required by law
- If the protected health information was obtained from someone other than us under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information .We may also deny a request for access to protected health information if:
- A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person
- The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person
- The request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person
- If we deny a request for access for any of the reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.

4. You have the right to request a correction to your protected health information, but we may deny your request for correction, if we determine that the protected health information or record that is the subject of the request:
   - Was not created by us, unless you provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment
   - Is not part of your medical or billing records
   - Is not available for inspection as set forth above
   - Is not accurate and complete

In any event, any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.

5. You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you for the period provided by law, except for disclosures:
   - To carry out treatment, payment and health care operations as provided above

- To persons involved in your care or for other notification purposes as provided by law
- For national security or intelligence purposes as provided by law
- To correctional institutions or law enforcement officials as provided by law
- That occurred prior to April 14, 2003
- That are otherwise not required by law to be included in the accounting

6. You have the right to request and receive a paper copy of this notice from us.
7. The above rights may be exercised only by written communication to us. Any revocation or other modification of consent must be in writing delivered to us.

Complaints

If you believe that your privacy rights have been violated, you should immediately contact our Practice or our Privacy Officer. All complaints must be submitted in writing. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services

By signing below, I authorize Healing For All, LLC to release or obtain medical information about me as described above.

Signature of Adult Patient or Legal Representative and Date:

____

Printed Name of Adult or Legal Representative:

____

Name of Patient (Minor):

____

423 Georgia Avenue, Suite 100, Atlanta, GA 30312 404-458-0382 T 678-355-2480 F

Release of Information

Authorization to Release or Obtain Health Care Information

Patient Name	
Address	
Birthdate	
Phone	

I hereby authorize Healing For All, LLC to request or release the medical information about me indicated below to the following person/intended recipient :

____

- I am aware that my records may contain information related to mental health, substance abuse and sexually transmitted diseases (including test results related to HIV/AIDS), and I specifically authorize the release of such information pursuant to this Authorization.
- I understand that this authorization will expire in one (1) year, but I may revoke it at any time in writing. I understand that any such revocation will not apply to any information already released under this Authorization.

Intended Recipient:	
Address:	
Phone:	Fax:
Email Address:	
Documents Needed:	
Purpose of Release: Continued Care Collaboration Requesting Specific Records Insurance Personal Disability Other:______________ Legal If for continued care, records are needed for doctor's appointment on: ___________________________	

This Authorization allows for exchange of medical information by telephone or other direct verbal communication in lieu of written communication.

Patient Signature: ______________________________________ Date: _________________________