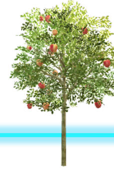
Dr. Cynthia Grow, PsyD, LMFT

Doctor of Applied Clinical Psychology, Trauma Specialist
Marriage & Family Therapist Lic. #85046 (CA) #2636 (FL)



drcynthiagrow.com » **352.242.8767 (c)**
cynthia@drcynthiagrow.com

INTAKE PACKET

Hello and Welcome!

I appreciate your courage in seeking therapy. This can feel like a huge step, but it's really like having skilled companionship on a safe, self-paced journey, customized specifically for you. Sometimes problems feel overwhelming and concentrated focus is important for relief. Sometimes just a "tune-up" is nice. Either way, you'll find me client-centered, compassionate, and gentle.

Please fill out this Intake Packet, providing complete answers to the best of your ability. **It's very important to thoroughly read ALL the information and sign where indicated.** If you would rather not answer a question, please write "n/a" and we can explore the answer(s) together in the safety of our sessions.

Though I am trained in multiple research-based therapeutic models (i.e., Cognitive Behavioral Therapy (CBT), Person Centered Therapy, Family Systems, Solution Focused, Dialectical Behavioral Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR), and others, my approach to therapy is eclectic, meaning I use the tools and skills I believe best fit you and your journey at any given time. I am very experienced with depression, anxiety, loss and grief, career search, life and professional transitions, pre-marital counseling, couples therapy, intimate partnerships, and more. I work with individuals, couples, and families, as well as those who may be feeling intense emotions, confused, detached, dissociated, overwhelmed, exhausted, and/or hopeless. I also have the honor and privilege of serving US military veterans and first responders.

I have three specialty areas: 1) Trauma/CPTSD/emotional pain recovery; 2) Emotional needs and coping skills for those who are highly sensitive, creative, intense, perfectionistic, and/or gifted, feel different from others, have difficulty making/keeping friends, miss social cues, etc., and 3) working with LGBTQI+ clients in areas of seeking gender transition, self-acceptance, depression, anxiety, isolation, guilt, shame, loss, deciding if/when to come out to friends and family, coping skills, life purpose, emotional sensitivity, and more. My family and I have personal experience with the challenges all three of these areas inherently contain.

Please note that our office policy is full payment for each session at the time of service. If you have insurance and choose to use it, please contact your insurance company to ensure you understand your mental health benefits for out-of-network providers. By request, I can email you a Superbill to send to your insurance company, and reimbursement will come from them directly to you.

Feel free to ask me any questions or raise any concerns at any time. I'm excited about our journey together and I look forward to seeing you soon!

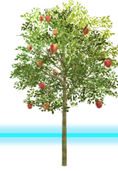
Warmly,

Dr. Cynthia Grow, PsyD, LMFT

Dr. Cynthia Grow, PsyD, LMFT

Dr. Cynthia Grow, PsyD, LMFT

Doctor of Applied Clinical Psychology, Trauma Specialist
Marriage & Family Therapist Lic. #85046 (CA) #2636 (FL)



drcynthiagrow.com » **352.242.8767 (c)**
cynthia@drcynthiagrow.com

PLEASE PRINT CLEARLY

NAME ____ DATE ____________

BEST EMAIL TO REACH YOU ____

Home Phone: ____________Work Phone: ____________Cell: ____________ Other ____________

Where may I leave messages? (Please check) Home voicemail ________ Office voicemail ________ Cell phone ________

May I text you? Y / N If yes, please provide your cell # above. You can change your mind anytime via email.

Home Address ________________________________City ______________Zip ________

Date of birth __________ Place of Birth ____________________ Age ______ SS # (last 4) ____________

Occupation ______________________ How Long _______Employer ____________________

Partner's Name __________________________ Partner's Occupation ____________________

Status: Single_____ Married_____ Divorced _____ Widowed _____ Partnered _____ Engaged_____ How Long? _____

Children's Names and Ages ____

ELECTRONIC RECORDS & INSURANCE

Please call your insurance company prior to your first session to ask about your mental health benefits. Payment for sessions is due at the time of service and may be made by check or credit card. I am not paneled with any insurance companies, therefore, when you talk with your insurance company I am considered "out of network." Upon request, I will provide you with a monthly Superbill, and your insurance company will reimburse you directly for your covered amount.

Referral Source

How did you find me?____

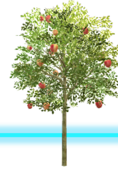
Current Concern(s)

Reason(s) for seeking therapy at this time:

____
____
____
____
____
____
____

Dr. Cynthia Grow, PsyD, LMFT

Doctor of Applied Clinical Psychology, Trauma Specialist
Marriage & Family Therapist Lic. #85046 (CA) #2636 (FL)



drcynthiagrow.com » 352.242.8767 (c)
cynthia@drcynthiagrow.com

Mental Health History

Please answer to the best of your ability – use the other side of these pages if needed.

Have you (or minor child) previously sought help for this or any other problem? If yes, please explain

____

____

Have you (or minor child) ever been hospitalized for psychological problems? If yes, explain and give approx. dates

____

____

Have you (or minor child) ever experienced suicidal ideation or attempted suicide? If so, when?

____

____

Have you (or minor child) ever harmed yourself, (ie, cutting, skin picking, pulling out hair/eyelashes/eyebrows, etc.)?

____

____

Have you (or minor child) ever taken prescribed medication for psychological problems? If yes, please give name(s) of medication, dosage, and approximate dates of use

____

____

Medical/Physical History

Have you (or minor child) had any significant health related events or conditions, including eating disorders?

____

____

Have you (or minor child) been hospitalized for any illnesses or conditions, including eating disorders?

____

____

Do you (or minor child) have any environmental allergies (ie, candles, perfumes, etc.)? If yes, please specify

____

____

Current medications for you (or minor child): medication name(s), dosage, name of the prescribing physician(s)—OR—please provide a list with the same information

____

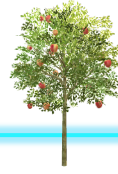
____

Family History

Your siblings and/or stepsiblings (ages and gender, or of your minor child)

____

____



drcynthiagrow.com » 352.242.8767 (c)
cynthia@drcynthiagrow.com

How was/is your (or minor child) relationship with siblings/stepsiblings

___

___

How was/is your (or minor child) relationship with your/his/her parents/step-parents

___

___

List any psychological problems in parents/step-p and/or siblings/step-s (ie, addictions, depression, anxiety, bipolar, etc.)?

___

___

Have you (or minor child) experienced physical, sexual, or emotional abuse? If yes, give age and date (no details necessary)

___

___

How often do you (or minor child) currently drink alcohol and/or take drugs?

___

___

Who, how often, and what types of alcohol/drugs were taken by **family members** during your (or minor child) childhood

___

___

Briefly describe how often and what types of alcohol and/or drugs are taken by your spouse and/or children **present time**

___

___

Social/Emotional History of You or Minor Child

Occupational History/Current Employment (write "student" if in school and not working)

___

___

Marital History (date of marriage, areas of conflict, date of separation or divorce(s) if applicable)

___

___

Educational History (include highest level of education, learning issues, social/friendship/relationship issues)

___

___

What people, organizations, and activities do you (or minor child) turn to during a crisis?

___

___

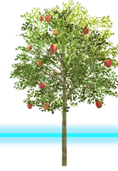
What losses have you experienced (ie, family member, pet, friend, or job loss or transition)? Please list type and year

___

___

Dr. Cynthia Grow, PsyD, LMFT

Doctor of Applied Clinical Psychology, Trauma Specialist
Marriage & Family Therapist Lic. #85046 (CA) #2636 (FL)



drcynthiagrow.com » **352.242.8767 (c)**
cynthia@drcynthiagrow.com

OFFICE POLICIES & PROCEDURES
PLEASE READ CAREFULLY

In Case of Emergency: ***If you need help immediately, always call 911 or go to your nearest emergency room.***

Contact Between Sessions: Please text me or leave a message on my confidential cell at 352.242.8767. I will return your text/call usually within 24-business hours. Returning calls on weekends is discretionary.

Confidentiality: Professional ethics and law dictate that whatever you say in a psychotherapy session will remain confidential and will not be shared with anyone without your written permission.

EXCEPTIONS to Confidentiality

- Disclosure of knowledge of child, elder, or dependent abuse – I am a madated reporter, meaning I am required by law to report knowledge of abuse to proper authorities or child protective services.
- Intention to harm yourself or someone else – By law I must take reasonable and precautionary measures to protect whoever is in danger. Threats communicated to family members that are then communicated to me may give rise to the duty to warn.
- Judicial Subpoena – Brief electronic records are kept regarding your treatment progress. Certain situations may arise where these records are subpoenaed by a judge, and I may be compelled to surrender them. This may occur when you become involved in a legal situation in which your psychological state is an issue.

Psychotherapy with Partners and/or Married Couples

- When engaging in couples therapy, whether married or single, it's important to know that I am not a referee and I will not take one side or the other. I am on the side of the "relationship" between you and your spouse or partner.
- "No Secrets Policy" – In the best interest of your relationship together, I will speak directly to the disclosing spouse or partner to recommend disclosure within the safety and confidentiality of a joint session, and I will encourage him/her to reveal the information to his/her spouse or partner FIRST, prior to disclosure by therapist.
    - However, after thorough exploration/discussion together, I reserve the right to disclose the information shared with me to provide a safe space to work through the issue(s) together for the health of your relationship.

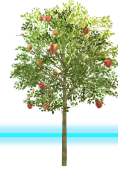
Treatment of Minors Under Age 18

- Parents (legal guardians) have the right to be informed of the psychological condition, progress, and treatment.
- It is important to understand that your child's progress in therapy can be directly related to the degree of confidentiality and trust they experience in their sessions and with their therapist.
- If your child is a potential threat to the safety of him/herself or others, this therapist will contact parent(s)/ guardian(s) immediately or at the first reasonable opportunity. If the child's safety is urgent and immediate this therapist's first call will be to 911 and then to parents/guardians.
- The treatment of minors in CA requires the consent of only one parent who has legal custody. *(CA Family Code §3083)*
- If one parent has sole custody, a **copy of the custody order is required** for the child/adolescent's therapy records.

Information Insurance Companies Can Request

If you are a member of and/or have been referred by an **agency, HMO, PPO, or other third-party payer**, I may be required to furnish information to that agency. Your signed agreement *with them* gives them permission to request information. Your signature below authorizes the following:

- Releasing required information to process claims with my payer.



- Furnishing information to a third-party payer about my psychological treatment to process payments/ benefits.
- Communication between Dr. Grow and her bookkeeping/office staff as well as other healthcare practitioners for professional consultation pursuant to coordination of my care, which can be delivered in person, by telephone/ videoconference, by written material, or by facsimile. Dr. Grow cannot be held responsible for maintaining confidentiality once information has left her office; therefore, I release Dr. Grow from liability.
- Clinical information may be written in a report to your Primary Care Physician (PCP). This communication is important for the coordination of your care, and Dr. Grow will first obtain your permission.
- I understand that my records may be reviewed by my insurance company to assure Quality-of-Care compliance.
- I understand that I have the right to access my Private Health Information (PHI) in my therapy file.
- I understand that I have the right to formally appeal decisions regarding authorized treatment services by contacting my health plan. I further understand that I have the right to submit a complaint or grievance to Dr. Grow regarding any aspect of my care. Additionally, I may submit complaints to my health plan or to the Secretary of the U.S. Dept. of Health and Human Services. I understand that I risk nothing in exercising these rights.

A photocopy of this release is to be considered as valid as the original. This authorization is subject to a modification/ revocation by either party at any time except to the extent that action has been taken in reliance hereon.

Your signature below also indicates that you have read and understood the foregoing policies and procedures, and you have received a copy of this document to refer to and for your files.

______________________________ ________ ______________________________
Signature of Client, Parent, or Legal Guardian | Date | Print Signatory's Name

Informed Consent for Treatment

As described below:

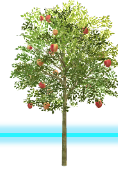
I , ______________________ and/or my minor child ______________________ accept menetal health services:
(Print Your Name) (Print Child's Name)

1. I give my authorization and consent to receive outpatient diagnostic and treatment services from Dr. Cynthia Grow, PsyD, LMFT.
2. I have been given information in this Intake Packet and understand my rights and responsibilities as a client.
3. I understand that engaging in psychotherapy may feel emotionally painful and does not guarantee a positive outcome. Therapeutic gains depend, in part, on a client's willingness to invest time, energy, and dedication into their own treatment.
4. I have been given information and understand the limits of confidentiality as a client.
5. I have been given information and understand the cost of services and financial agreement.
6. I understand that I am responsible for payment at the time of service.
7. I understand I must pay the full session fee if I do not cancel/reschedule PRIOR TO 24-hours of my appointment.
8. I have been given notice and understand office policies and procedures.
9. I am freely choosing to enter treatment, and I understand that I may discontinue treatment at any time.

______________________________ ________ ______________________________
Signature of Client, Parent or Legal Guardian | Date | Print Signatory's Name

Dr. Cynthia Grow, PsyD, LMFT

Doctor of Applied Clinical Psychology, Trauma Specialist
Marriage & Family Therapist Lic. #85046 (CA) #2636 (FL)



drcynthiagrow.com » 352.242.8767 (c)
cynthia@drcynthiagrow.com

Financial Agreement & Authorization for Psychological Services

Full payment is due when services are rendered. Photos or scans of your credit card of choice are required to charge for session fees or missed appointments that occur within the 24-hour cancellation window (see below). If you have any concerns about this office policy, please discuss them with Dr. Grow. Session fees will be reimbursed directly to you by your insurance company according to your mental health benefits. Upon request, Dr. Grow will provide you a Superbill to submit to your insurance company for reimbursement. When providing treatment for a minor child, all professional services are the responsibility of the parent(s)/legal guardian. *If you belong to a First Responder organization the session fees are generally covered by the organization except for any cancellation/reschedule fees.* If you have any questions, please ask Dr. Grow.

Returned Payment: If your payment is returned for insufficient funds, there will be a $40.00 administrative fee, which will be added to your account in addition to the session fee and due at the next session.

Aging Payments: In the event collection or legal action should become necessary to collect any unpaid balance for services rendered, your signature below signifies agreement to pay collection, attorney, and court costs. A copy of this assignment is as valid as the original.

ALL CLIENTS ARE REQUIRED TO PLACE A CREDIT, DEBIT, OR HSA CARD ON FILE FOR CANCELLATIONS WITHIN 24-HOURS OF THEIR SCHEDULED APPOINTMENT.

Cancellation/Reschedule: My customary fee is $200 per session. Because scheduled appointment times are reserved only for you (or your minor child) and is valuable time that could be scheduled for someone else in need, ALL clients are required to have a credit, debit, or HSA card on file with permission to charge the FULL AMOUNT for a missed or cancelled session without a minimum of 24-hours' notice.

If you are a first responder and mandated to work on the day of your scheduled appointment, please advise Dr. Grow as soon as possible.

Thank you for respecting these requirements.

Please email scans or pictures of the front and back of your preferred card along with pages 2-9 of this packet to cynthia@drcynthiagrow.com. Once your card info is entered into our encrypted therapy software the pictures will be destroyed. The only information visible in our software is the expiration date and last four digits of your card info.

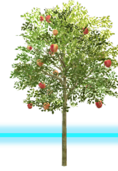
My signature below signifies I understand this financial agreement as explained above, and I have had the opportunity to ask questions and receive satisfactory answers. My signature also authorizes Dr. Cynthia Grow, PsyD, LMFT, to store scans or pictures of my credit card front and back in my confidential, encrypted electronic file for the purpose of charging session fees at the time services are rendered or charge the full fee for cancellation within 24-hours' notice, except for unexpected work mandated by my employer.

Name as it appears on credit card: (Print) ____

Authorized Signature ____ Date ______________

Dr. Cynthia Grow, PsyD, LMFT

Doctor of Applied Clinical Psychology, Trauma Specialist
Marriage & Family Therapist Lic. #85046 (CA) #2636 (FL)



drcynthiagrow.com » **352.242.8767 (c)**
cynthia@drcynthiagrow.com

PHONE or VIDEO SESSIONS (Telehealth)

This Intake section outlines the circumstances, procedures, and expectations for participating in telehealth. Out of an abundance of caution in response to the World Health Organization's March 11, 2020, declaration of COVID-19 as a global pandemic, as well as national, state, and local declarations of emergency, my practice has moved to phone and/or video-based services using **Doxy.me and Psychology Today Sessions (PTS),** which are free HIPAA compliant Telehealth platforms.

Participating in Telehealth services requires agreement to the following

- Client will provide their own technology (including a secure internet connection, video/webcam, microphone and audio). A smart phone will work, but it is not ideal.
- Client agrees to originate their appointment from a **non-public location that allows privacy** and minimizes the ability of the appointment being overheard. Consider using a white noise machine outside the room if you think you might be overheard by others. It is strongly recommended that the client use earphones/earbuds if privacy is not available.
- It is requested that you place a "do not disturb" notice on the closed-door room you will use.
- Client agrees to not initiate their Telehealth appointment in a public place, while driving a car, using public transportation, or being a passenger in a car (for privacy requirements).
- Client agrees to participate in Telehealth services dressed appropriately, as if they were attending in-person appointments.
- Client agrees not to record any session or part of session without specifically obtaining permission from Therapist.
- **If Client does not uphold the expectation of providing a safe and confidential space, the appointment will be ended, and the client will be responsible for fees associated with appointment cancellation.**

Consent for Telehealth Services

- I understand that my provider has offered me Telehealth Services.
- I understand that the information transmitted during Telehealth Services will not be recorded without permission.
- My provider has explained that receiving services using phone and/or video conferencing will not be the same as an in-person office visit because I will not be in the same room as the provider.
- I understand that Telehealth services have potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
- I understand that there are potential risks to Telehealth including interruptions, unauthorized access, and technical difficulties.
  - **I understand that if there is a service disruption due to technology failure, that my provider will call me by telephone to continue the appointment in this format.**
  - I understand that the provider or I can request to discontinue the Telehealth services if it is agreed that the video-conferencing connections are not adequate for this situation.
- I understand I can have a direct conversation with my provider, during which I can ask questions about Telehealth services.

Consent to Use a Secure Telehealth Platform. By signing this document, I acknowledge that the telehealth platform used in my therapy sessions ***is not an emergency service***. **In the event of an emergency, it is YOUR responsibility to call 911**.

- Though my provider and I will be in direct, virtual contact using telehealth, I understand the telehealth platform itself and my therapist do not provide any medical services or medical advice, including but not limited to emergency or urgent medical services.
- I do not assume or expect that my provider has access to technical information about the telehealth platforms.

- To maintain confidentiality, I will not share the telehealth appointment link with anyone unauthorized to attend the appointment.

My signature immediately below signifies that:

- I have read this form or had this form read and/or explained to me.
- I fully understand its contents including the risks and benefits of receiving Telehealth through telephone and/or videoconferencing.
- I have been given ample opportunity to ask questions, and my questions have been answered to my satisfaction.
- I agree to provide the environmental conditions outlined above to ensure safe and confidential sessions.
- I agree to attend sessions in appropriate attire as if sessions were being held in person.

Signature	Date	Print Name

****

Healthcare Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices
(This form fulfills and/or exceeds the current HIPAA requirements)

Effective Date

I acknowledge that on the following pages (pp. 10-13 herein) I have received a copy of the Healthcare Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices and agree to its terms and conditions.

Signature of Client or Legal Representative	Date	Print Name of Client or Legal Representative

****

Keep this entire Intake Packet for your records

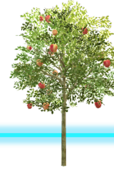
PLEASE SCAN AND RETURN PAGES 2 – 9 OF THIS INTAKE PACKET ALONG WITH SCANS OR PHOTOS FRONT AND BACK OF YOUR PREFERRED PAYMENT METHOD.

EMAIL THEM TO:
cynthia@drcynthiagrow.com
at lease 24-hours prior to your scheduled appointment.

Thank you! I'm looking forward to our work together!

Dr. Cynthia Grow, PsyD, LMFT

Doctor of Applied Clinical Psychology, Trauma Specialist
Marriage & Family Therapist Lic. #85046 (CA) #2636 (FL)



drcynthiagrow.com » 352.242.8767 (c)
cynthia@drcynthiagrow.com

Healthcare Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices
(This form fulfills and/or exceeds the current HIPAA requirements)

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

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to ensure that your protected health information (PHI) is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. These changes will be made based on the legal and ethical standards of my profession and as required law. In addition, I may be required to change this Notice as future adjustments to HIPAA is so ordered by the Federal Government. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office and on my website. You may also request a copy of this Notice from me, or you can view a copy of it in my office. While the new HIPAA standard are intended to provide minimal and consistent standards across all health care profession, as a Psychologist I must adhere to a higher ethical standard. Consequently, no information about you will be disclosed without your knowledge and/or consent, unless they are classified as exceptions to confidentiality. Those exceptions are listed below.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

As stated in your confidentiality agreement with me, I will disclose information in your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the exceptions to confidentiality and uses that would require partial or complete disclosure of your PHI.

1. **To obtain payment for treatment.** I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office. Note that this information is limited to only that which is required for collections.

2. **Medical Emergencies.** Your consent is not required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you pass out in my office and are unconscious) but I think that you would consent to such treatment if you could, I may disclose your PHI, providing limited information i.e. demographics and medical information to secure appropriate medical care.

3. **If disclosure is compelled by a judge.**

4. If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.

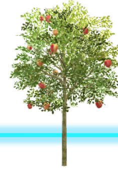
5. **To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public. Specifically, if you tell me you intent to commit a crime, I must report it to the police.

6. **Dangerousness to self or others.** If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.

7. **If disclosure is mandated by the California Child Abuse and Neglect Reporting law.** For example, if I have a reasonable suspicion of child abuse or neglect.

Dr. Cynthia Grow, PsyD, LMFT

Doctor of Applied Clinical Psychology, Trauma Specialist
Marriage & Family Therapist Lic. #85046 (CA) #2636 (FL)



drcynthiagrow.com » 352.242.8767 (c)
cynthia@drcynthiagrow.com

8. **If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law.** For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.

9. **If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.** I am also required to warn the persons or persons to whom the threat is made or any other person(s) who could be injured as a part of that threat.

10. **For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.

11. **Legal proceedings.** If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.

12. **For Consultation.** I may speak with professional colleagues about our work without asking permission, but your identity will be disguised.

13. **Administrative purpose.** An administrative assistant employed by me may have access to locked records but is legally charged with confidentiality.

14. **Minors.** Clients under 18 do not have full confidentiality from their parents. Parents may request their child(ren)'s PHI. However, the request may compromise trust and safety and undermine the therapeutic process. Consequently, parents are asked to respect the confidentiality of their child(ren)'s treatment, knowing that they will be informed if the minor shares information that requires me to legally and/or ethically break confidentiality and/or shares information indicating that the minor is physically at risk/danger.

15. I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other heath-related benefits and services that may be of interest to you.

16. If disclosure is otherwise specifically required by law and is not in conflict with my ethical requirements. At all times, I will strive to comply with the highest ethical and legal standard to insure your privacy, confidentiality, and clinical care.

IV. OTHER USES AND DISCLOSURES REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION.

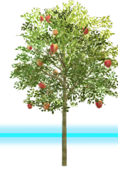
In any other situation not described in Section III above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

V. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

A. **The Right to See and Get Partial Copies of Your PHI.** In general, you have the right to see your PHI that is in my possession; however, you must request it in writing. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed. You may ask for copies of your PHI, I will charge you not more than $.25 per page for information that you have provided such as demographics and history as contained in your Client Questionnaire. Clinical information will not be released to you directly. Clinical information may be sent to another professional i.e. therapist, attorney with your consent: I may see fit to provide them with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. **The Right to Choose How I Send Your PHI to You.** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience and which does not violate your privacy and/or confidentiality.

C. **The Right to Get a List of the Disclosures I Have Made.** You are entitled to a list of disclosures of your PHI that I have made. However, the list will not include uses or disclosures to which you have already consented or disclosures made before April 15, 2003. After April 15, 2003, HIPAA requires that disclosure records will be held for six years. However, in compliance with the standards of my profession, all records will be held for a minimum of seven years unless otherwise indicated. Note records may be maintained longer if it is clinically warranted and in the best interest of the individual to do so. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the



drcynthiagrow.com » **352.242.8767 (c)**
cynthia@drcynthiagrow.com

information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

D. **The Right to Amend Your PHI.** If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

VI. COMPLAINTS

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a written complaint with me either in person or by mail to my letterhead address. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you. Complaints may also be filed with the California Board of Psychology. 1422 Howe Avenue, Suite 22, Sacramento, CA 95825-3200, (916) 263-2699.

This notice was updated and revised on October 2, 2014.

1 *Protected Health Information* refers to information in your health record that could identify you. Protected health information records include the minimum possible information about therapy such as dates, diagnosis, medications, crisis risk, symptoms, test results, billing, and treatment plans.

2 *Treatment* is when I or another health care provider diagnoses or treats you. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist, regarding your treatment.

3 *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.

4 *Health Care Operations* is when I disclose your PHI to your health care service plan (your health insurer for example) or to your other health care providers contracting with your plan, or administering the plan, such as case management and care coordination.

5 *Use* applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information and identifies you.

6 *Disclosure* applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.