Psychological Consulting Services, Inc.
Sharon D. Heaston, LMFT
237 A W. 4th Street, Claremont, CA 91711-4101
Phone (909) 945-8894 | Fax (909) 945-2855 |psychevalspcs@gmail.com

INSTRUCTIONS

❶ Download this document as a PDF and open the document in Adobe Reader. You can find more detailed instructions on how to download and install Adobe Reader at: https://helpx.adobe.com/acrobat/kb/install-reader-dc-windows.html

❷ How to Create a Digital Signature

1. Open Document in Adobe Reader
2. Click on the signature field.
3. A box will come up that asks you how you want to create your digital signature. Click "Configure Digital ID"
4. Click "Create a new Digital ID"
5. Click "Save to file"
6. Fill out the next screen including your email.
7. Create a password that you will use to sign the remainder of the document.

❸ Attached please find the Intake Forms for your Psychological Evaluation for your surgery. **We need these back before you have your session.** Please fax these to (909) 945-2855 or you can scan and email them to: psychevalspcs@gmail.com. Please return these to us as soon as possible. The intake forms are as follows:

Personal Information
Please use the fillable spaces to type on to fill out your personal information. Please be sure to check those boxes that apply to you.

Payment Information
If you have Kaiser or Primecare insurance and are a patient of Suh Bariatric or a referral from Crown Surgery, please disregard this section. If you are not, please fill in the typeable forms including your Name and all the Credit Card information. Your credit card will be used to bill your $150 Evaluation fee. If you would like a SuperBill so you can file the claim with your insurance company, please fill out the insurance information and request it.

Authorization to Release Confidential Information
Please type in your first and last name in the appropriate box followed by the name of your surgeon in the designated space. Please also insert your digital signature (see instructions above on how to do this) in the space marked signature. Please also be sure to fill out the date.

Acknowledgement of Receipt of Notice of Privacy Practices
Please insert your digital signature in the space marked signature. Please also be sure to fill out the date.

Teleconference Informed Consent Form

The appointment time you have been offered is for a HIPPA complaint teleconference. If this is not what you want, please email us as you will be given an alternate time to come into our office. I am attaching instructions on how to check in for your Teleconference appoint.

FOLLOW THESE INSTRUCTIONS

1. DO NOT DOWNLOAD THE DOXY APP.

2. IN CHROME OR SAFARI BROWSER TYPE IN THE BROWER BAR: DOXY.ME/SH

3. YOU WILL BE SENT TO THE "ROOM"

4. YOU MUST ALLOW DOXY ACCESS TO YOUR CAMERA AND MICROPHONE

5. WAIT UNTIL SHARON CLICKS ON YOU YOU WILL AUTOMATICALLY BE CONNECTED

Please practice a test call prior to your appointment. If you are unable to access Doxy, please give us 48 hours advance notice of cancellation to avoid a missed session fee.

Please type your name on the consent form and follow it by inserting your digital signature..

Previous Weight Loss Methods
For this section please use the checkboxes and check each weight loss method that you have tried. You can select more than one checkbox in this section. For Excessive Exercise please type in what type of exercise, the weight loss obtained from that exercise, and the method of exercise.

Eating Behavior
Please use the checkboxes to check which eating behaviors you partake in. You can select more than one checkbox in this section.

Eating Profile Questionnaire
Please complete by checkmarking the boxes.

Michigan Alcoholism Screening Test
If you do not drink, please insert your digital signature where required followed by the date. If you do drink alcohol, please check the corresponding checkboxes on each question.

Bourne Anxiety Index
Please read over each question and use the checkbox to select one of the responses rating from 0-3.

Beck Depression Inventory
Please fill out the top portion of this assessment in the typeable fields provided. While doing the assessment please check one of the checkboxes that best corresponds with the question.

HIPPA Notice of Privacy Practices
This section is for you to keep. You do not need to sign or fill out anything. This is for your records.

Personal Information

Date: Referring Doctor:

Name: Birth Date: Age:

Home Phone: Work Phone: Cell Phone:

Address:

Marital History: (Select) Sex: (Select)

Children(s) Ages: Highest Level of Education: (Select)

Who do you live with?

Height: Weight:

Occupation: ☐ Full Time ☐ Part Time

Email Address: Are we free to contact you by: ☐ Email ☐ Text
(Please check the method of contact we are authorized to use)

Payment Information If you are a Suh Bariatric patient with Kaiser or Primecare insurance or a Crown Surgery referral, please disregard this section.

If not, please complete the following:

Name of Insurance:

Name & ID Number on Card:

Co-Pay:

Form of payment: ☐ Visa ☐ American Express ☐ MasterCard ☐ Other:

Name on Card:

Credit Card Number:

Billing Zip Code: CVV#: Expiration:

With your signature below you authorize Psychological Consulting Services, Inc. to charge your credit card $150 for the Evaluation fee.

Client Signature Date

Client Signature Date

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, (Name of Patient) _____ hereby authorize Sharon D. Heaston, LMFT
to release confidential information obtained during the course of my Assessment to (Name of Doctor):_____.

This Authorization permits the release of the following information:

Complete Psychological Assessment.

I authorize this Release of Information described above for the following purpose: To be considered a Candidate for Weight Loss Surgery. The Recipient may use the information described above solely for the above purpose.

I understand that I have a right to receive a copy of this Authorization. I also understand that any cancellation or modification of this Authorization must be in writing.

Signature:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

With your signature below, you acknowledge that you have received the HIPPA Notice Of Privacy Practices. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my Notice, you may obtain a copy of the revised Notice from me by contacting me at (909)-945-8894.

If you have any questions about my Notice of Privacy Practices, please contact me at:

(909)-945-8894.

Signature:_____ Date:_____

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TELEMEDICINE INFORMED CONSENT FORM

I, (Name of Patient) _____ hereby consent to engaging in telemedicine with Sharon D. Heaston, LMFT as part of my psychological evaluation, assessment and psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical mental information, both orally and visually, to health care practitioners located in California or outside California. I understand that I have the right to:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentially, including but not limited to: reporting child, elder and dependent adult abuse; expressed threats of violence towards ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent

(3) I understand that there are risk and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapists, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of any medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine-based services and care may not be as complete as face-to- face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some case even get worse.

(4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with California law.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction. Listed below please find my signature and the date:

Signature:_____ Date:_____

How to check in for your video visit

1 Use a computer or device with camera/microphone

PC and Mac
Chrome | Firefox | Safari

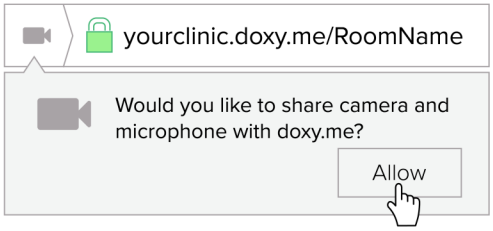
Android
Chrome

iOS
Safari

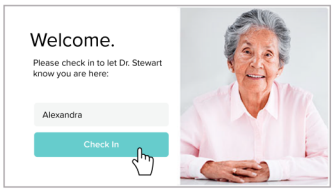
2 Enter your clinician's doxy.me web address into the browser

DO NOT DOWNLOAD AN APP

3 Allow your browser to use your webcam and microphone



4 Type in your name and click check in



- ✓ Secure
- ✓ No software to download
- ✓ HIPAA compliant
- ✓ No registration needed

5 Your care provider will start your visit

Call Tips

- Make sure you have a good internet connection
- Restart your device before the visit
- Test your camera and mic from the waiting room
- Need help? Send us a message https://doxy.me

PREVIOUS WEIGHT LOSS METHODS

Name:_____ Marital Status: (Select) Age:_____ Sex: (Select)

Occupation:_____ Education: (Select)

☐ Doctor ☐ Nutritionist ☐ Prescribed Diet ☐ Lindora ☐ Jenny Craig ☐ Nutri-System

☐ Weight Watchers ☐ Vegetarian Diet ☐ Liquid Diets ☐ Fad Diets ☐ Fasting

☐ Hypnosis ☐ Overeaters Anonymous ☐ TOPS ☐ Acupuncture ☐ Ear Stapling

☐ Prescription Diet Pills ☐ Over the Counter Pills ☐ Jaw Wiring ☐ Laxatives

☐ Vomiting ☐ Balloon in Stomach ☐ Stomach Stapling ☐ Other Gastric Surgery's

☐ Excessive Exercise: Type_____ Weight Loss_____ Method:_____

EATING BEHAVIOR

☐ Portions Too Large ☐ Often take Seconds ☐ Skip Meals ☐ Frequent Snacks
☐ Binge

☐ Fast Food: How Many Times Per Week? ☐ 1-2 ☐ 3-4 ☐ More than 5

☐ Secret Eating ☐ Eat Past Satisfaction ☐ Eat Past Full to Stuffed ☐ Eat Fast

☐ Don't Chew Well ☐ Always Clean Plate ☐ Rarely Hungry ☐ Always Hungry

Overeat when I feel:

☐ Depressed ☐ Angry ☐ Nervous ☐ Happy

Hard to resist Foods when I'm

☐ Bored ☐ Lonely ☐ Worried ☐ Excited ☐ Celebrating

EATING PROFILE QUESTIONNAIRE

Name:_____ Marital Status: (Select) Age:_____ Sex (Select)

Occupation:_____ Education: (Select)

	Yes	No
1. Do you often eat standing up?	☐	☒
2. Is it difficult for you to remember everything you ate today?	☐	☒
3. Is it difficult for you to remember everything you ate yesterday?	☐	☒
4. Do you often eat between meals?	☐	☒
5. Do you tend to finish your food before others?	☐	☒
6. Do you often not use plates or utensils when eating?	☐	☒
7. Do you frequently do other things while eating?	☐	☒
8. Is quality of food more important than the quantity?	☐	☒
9. Do you tend to eat slowly?	☐	☒
10. Do you enjoy trying different types of food?	☐	☒
11. Do you love high-fat or high-sugar foods?	☐	☒
12. Do you pass on food that isn't tasty?	☐	☒
13. Is eating one of your greatest pleasures?	☐	☒
14. Are you a nervous or a high-strung person?	☐	☒
15. Do you often snack when you're tense or uptight?	☐	☒
16. Is it hard for you to resist eating something that is right in front of you?	☐	☒
17. Is the act of eating often more important than what you are eating?	☐	☒
18. Is it difficult for you to relax?	☐	☒
19. Are you a worrier?	☐	☒
20. Is it difficult for you to be assertive?	☐	☒
21. Do you have upsetting dreams?	☐	☒
22. Do you often eat to avoid thinking about being upset?	☐	☒
23. Is it sometimes hard for you to identify your feelings?	☐	☒
24. Do you have problems that seem insurmountable?	☐	☒
25. Are you a people pleaser?	☐	☒
26. Do you have special feel-good foods?	☐	☒
27. Does eating initially give you a lift or a high?	☐	☒
28. Do you often feel sad, bored or down in the dumps?	☐	☒
29. Do you often plan out food treats for yourself?	☐	☒
30. Are you overly critical of yourself?	☐	☒
31. Do you lack energy or enthusiasm?	☐	☒

MICHIGAN ALCOHOLISM SCREENING TEST

Name:_____ Marital Status: (Select) Age:_____ Sex: (Select)

Occupation:_____ Education: (Select)

Please answer Yes or No to the following questions.

IF YOU DO NOT DRINK PLEASE ACKNOWLEDGE SO WITH YOUR SIGNATURE BELOW. YOU DO NOT HAVE TO COMPLETE THE QUESTIONNAIRE.

I do not consume alcohol.

Signature:_____ Date:_____

1. Do you feel you are a normal drinker? ("normal" is defined as drinking as much or less than most other people) ☐ Yes ☐ No
2. Have you ever awakened the morning after drinking the night before and found that you could not remember a part of the evening? ☐ Yes ☐ No
3. Does any near relative or close friend ever worry or complain about your drinking? ☐ Yes ☐ No
4. Can you stop drinking without difficulty after one or two drinks? ☐ Yes ☐ No
5. Do you ever feel guilty about your drinking? ☐ Yes ☐ No
6. Have you ever attended a meeting of Alcoholics Anonymous (AA)? ☐ Yes ☐ No
7. Have you ever gotten into physical fights when drinking? ☐ Yes ☐ No
8. Has drinking ever created problems between you and a near relative or close friend? ☐ Yes ☐ No
9. Has any family member or close friend gone to anyone for help about your drinking? ☐ Yes ☐ No
10. Have you ever lost friends because of your drinking? ☐ Yes ☐ No
11. Have you ever gotten into trouble at work because of drinking? ☐ Yes ☐ No
12. Have you ever lost a job because of drinking? ☐ Yes ☐ No
13. Have you ever neglected your obligations, family, or work for two or more days in a row because you were drinking? ☐ Yes ☐ No
14. Do you drink before noon fairly often? ☐ Yes ☐ No
15. Have you ever been told you have liver trouble, such as cirrhosis? ☐ Yes ☐ No

MICHIGAN ALCOHOLISM SCREENING TEST, Continued

16. After heavy drinking, have you ever had delirium tremens (DTs), severe shaking, visual or auditory (hearing) hallucinations? ☐ Yes ☐ No

17. Have you ever gone to anyone for help about your drinking? ☐ Yes ☐ No

18. Have you ever been hospitalized because of drinking? ☐ Yes ☐ No

19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward? ☐ Yes ☐ No

20. Have you ever gone to any doctor, social worker, clergyman, or mental health clinic for help with any emotional problem in which drinking was part of the problem? ☐ Yes ☐ No

21. Have you been arrested more than once for driving under the influence of alcohol? ☐ Yes ☐ No

22. Have you ever been arrested, or detained by an official for a few hours because of other behavior while drinking? ☐ Yes ☐ No

BOURNE ANXIETY INDEX

Name:_____ Marital Status: (Select) Age:_____ Sex (Select)

Occupation:_____ Education: (Select)

Anxious Feelings	Not at All-0	Somewhat-1	Moderately-2	A lot-3
1. Anxiety, nervousness, worry or fear	☐	☐	☐	☐
2. Feeling that things around you are strange, unreal or foggy	☐	☐	☐	☐
3. Feeling detached from all or part of your body	☐	☐	☐	☐
4. Sudden, unexpected panic spells	☐	☐	☐	☐
5. Apprehension or a sense of impending doom	☐	☐	☐	☐
6. Feeling tense, stressed, uptight or on edge	☐	☐	☐	☐

Anxious Thoughts	Not at All-0	Somewhat-1	Moderately-2	A lot-3
7. Difficulty concentrating	☐	☐	☐	☐
8. Racing thoughts	☐	☐	☐	☐
9. Having your mind jump from one thought to the next	☐	☐	☐	☐
10. Frightening fantasies or daydreams	☐	☐	☐	☐
11. Feeling like you are on the verge of losing control	☐	☐	☐	☐
12. Fears of cracking up or going crazy	☐	☐	☐	☐
13. Fears of fainting or passing out	☐	☐	☐	☐
14. Fears of physical illness, heart attacks or dying	☐	☐	☐	☐
15. Concerns about looking foolish or inadequate in front of others	☐	☐	☐	☐
16. Fears of being alone isolated or abandoned	☐	☐	☐	☐
17. Fears of criticism or disapproval	☐	☐	☐	☐
18. Fears that something terrible is about to happen	☐	☐	☐	☐

Physical Symptoms	Not at All-0	Somewhat-1	Moderately-2	A lot-3
19. Skipping, Racing or pounding of the heart	☐	☐	☐	☐
20. Pain, pressure or tightness in the chest	☐	☐	☐	☐
21. Tingling or numbness in the toes or in the fingers	☐	☐	☐	☐
22. Butterflies or discomfort in the stomach	☐	☐	☐	☐
23. Constipation or diarrhea	☐	☐	☐	☐
24. Restlessness or jumpiness	☐	☐	☐	☐
25. Tight or tense muscles	☐	☐	☐	☐
26. Sweating not brought on by heat	☐	☐	☐	☐
27. A lump in the throat	☐	☐	☐	☐
28. Rubbery or "jelly" legs	☐	☐	☐	☐
29. Feeling dizzy, light-headed or off balance	☐	☐	☐	☐
30. Choking, smothering sensation or difficulty breathing	☐	☐	☐	☐
31. Headaches or pains in the neck or back	☐	☐	☐	☐
32. Trembling or shaking	☐	☐	☐	☐
33. Hot flashes or cold chills	☐	☐	☐	☐
34. Feeling tired, weak or easily annoyed	☐	☐	☐	☐

Bourne Anxiety Index Score: 0

BECK DEPRESSION INVENTORY

Name:_____ Marital Status (Select) Age:_____ Sex (Select)

Occupation:_____ Education (Select)

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past wo weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
   - ☐ 0 I do not feel sad
   - ☐ 1 I feel sad much of the time
   - ☐ 2 I am sad all the time
   - ☐ 3 I am so sad or unhappy that I can't stand it.
2. Pessimism
   - ☐ 0 I am not discouraged about my future
   - ☐ 1 I feel more discouraged about my future than I used to be
   - ☐ 2 I do not expect things to work out for me
   - ☐ 3 I feel my future is hopeless and will only get worse
3. Past Failure
   - ☐ 0 I do not feel like a failure
   - ☐ 1 I have failed more than I should have
   - ☐ 2 As I look back, I see a lot of failures
   - ☐ 3 I feel I am a total failure as a person
4. Loss of Pleasure
   - ☐ 0 I get as much pleasure as I ever did from the things I enjoy
   - ☐ 1 I don't enjoy things as much as I used to
   - ☐ 2 I get very little pleasure from the things I used to enjoy
   - ☐ 3 I can't get any pleasure from the things I used to enjoy
5. Guilty Feelings
   - ☐ 0 I don't feel particularly guilty
   - ☐ 1 I feel guilty over many things I have done or should have done
   - ☐ 2 I feel quite guilty most of the time
   - ☐ 3 I feel guilty all of the time
6. Punishment feelings
   - ☐ 0 I don't feel I am being punished
   - ☐ 1 I feel I may be punished
   - ☐ 2 I expect to be punished
   - ☐ 3 I feel I am being punished
7. Self-Dislike
   - ☐ 0 I feel the same about myself as ever
   - ☐ 1 I have lost confidence in myself
   - ☐ 2 I am disappointed in myself
   - ☐ 3 I dislike myself
8. Self-criticalness
   - ☐ 0 I don't criticize or blame myself more than usual
   - ☐ 1 I am more critical of myself than I used to be
   - ☐ 2 I criticize myself for all of my faults
   - ☐ 3 I blame myself for everything bad that happens
9. Suicidal thoughts or Wishes
   - ☐ 0 I don't have any thoughts of killing myself
   - ☐ 1 I have thoughts of killing myself, but I would not carry them out
   - ☐ 2 I would like to kill myself
   - ☐ 3 I would kill myself if I had the chance
10. Crying
    - ☐ 0 I don't cry any more than I used to
    - ☐ 1 I cry more than I used to
    - ☐ 2 I cry over every little thing
    - ☐ 3 I feel like crying, but I can't

Subtotal Page 1

0

BECK DEPRESSION INVENTORY, Continued

11. Agitation
    - ☐ 0 I am no more restless or wound up than usual
    - ☐ 1 I feel more restless or wound up than usual
    - ☐ 2 I am so restless or agitated that it's hard to stay still
    - ☐ 3 I am so restless or agitated that I have to keep moving or doing something
12. Loss of Interest
    - ☐ 0 I have not lost interest in other people or activities
    - ☐ 1 I am less interested in other people or things than before
    - ☐ 2 I have lost most of my interest in other people or things
    - ☐ 3 It's hard to get interested in anything
13. Indecisiveness
    - ☐ 0 I make decisions about as well as ever
    - ☐ 1 I find it more difficult to make decisions than usual
    - ☐ 2 I have much greater difficulty in making decisions than I used to
    - ☐ 3 I have trouble making any decisions
14. Worthlessness
    - ☐ 0 I do not feel I am worthless
    - ☐ 1 I don't consider myself as worthwhile and useful as I used to
    - ☐ 2 I feel more worthless as compared to other people
    - ☐ 3 I feel utterly worthless
15. Loss of Energy
    - ☐ 0 I have as much energy as ever
    - ☐ 1 I have less energy than I used to have
    - ☐ 2 I don't have enough energy to do very much
    - ☐ 3 I don't have enough energy to do anything

Subtotal Page 2
0
Subtotal Page 1
0
Total
0

16. Changes in Sleeping Pattern
    - ☐ 0 I have not experienced any change in my sleeping pattern
    - ☐ 1 I sleep somewhat more than usual
    - ☐ 1 I sleep somewhat less than usual
    - ☐ 2 I sleep a lot more than usual
    - ☐ 2 I sleep a lot less than usual
    - ☐ 3 I sleep most of the day
    - ☐ 3 I wake up 1-2 hours early and can't get back to sleep
17. Irritability
    - ☐ 0 I am no more irritable than usual
    - ☐ 1 I am more irritable than usual
    - ☐ 2 I am much more irritable than usual
    - ☐ 3 I am irritable all the time
18. Changes in Appetite
    - ☐ 0 I have not experienced any change in my appetite
    - ☐ 1 My appetite is somewhat less than usual
    - ☐ 1 My appetite is somewhat greater than usual
    - ☐ 2 My appetite is much less than before
    - ☐ 2 My appetite is much greater than usual
    - ☐ 3 I have no appetite at all
    - ☐ 3 I crave food all the time
19. Concentration Difficulty
    - ☐ 0 I can concentrate as well as ever
    - ☐ 1 I can't concentrate as well as usual
    - ☐ 2 It's hard to keep my mind on anything for very long
    - ☐ 3 I find I can't concentrate on anything
20. Tiredness or Fatigue
    - ☐ 0 I am no more tired or fatigued than usual
    - ☐ 1 I get more tired or fatigued more easily than usual
    - ☐ 2 I am too tired or fatigued to do a lot of the things I used to do
    - ☐ 3 I am too tired or fatigued to do most of the things I used to do
21. Loss of Interest in Sex
    - ☐ 0 I have not noticed any recent change in my interest in sex
    - ☐ 1 I am less interested in sex than I used to be
    - ☐ 2 I am much less interested in sex now
    - ☐ 3 I have lost interest in sex completely

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PLEASE KEEP THIS NOTICE OF PRIVACY PRACTICES FOR YOUR FILE
DO NOT RETURN

NOTICE OF PRIVACY PRACTICES

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

II. **I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)**
I am legally required to protect the privacy of your PHY, which includes information that can be used to identify you that I've created or received about your past, present or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is release, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice. However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website (if applicable). You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website which is located at www.sharonheaston.com.

III. **HOW I MAY USE AND DISCLOSE YOUR PHI**
I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. **Uses and Disclosures Relating to Treatment, Payment, or Heal Care Operations Do Not Require Your Prior Written Consent**. I can use and disclose your PHI without your consent for the following reasons:

1. **For Treatment.** I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

2. **To Obtain Payment for Treatments**. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For examples, I might send your PHI to your insurance

company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

3. **For Health Care Operations.** I can use and disclose your PHO to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

4. **Patient Incapacitation or Emergency.** I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as I try to get our consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. **Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization.** I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state, or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.

2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.

3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.

4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to a government official an adverse reaction that you have to medication.

5. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider organization.

6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.

7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.

8. To remind you about appointments and to inform you of health-related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other heal care services, or other health care benefits that I offer that may be of interest to you.

C. **Certain Uses and Disclosures Require You to Have the Opportunity to Object.**

1. **Disclosures to Family, Friends, or Others**. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. **Other Uses and Disclosures Require Your Prior Written Authorization**. In any other situation not described in sections III A, B, C above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. **The Right to Request Restrictions on My Uses and Disclosures**. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members or friends or others involved in our care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.

B. **The Right to Choose How I send PHI to You**. You have the right to request that I send confidential information to you to at an alternate address (for example, sending information to your work address rather than you home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. **The Right to Inspect and Receive a Copy of Your PHI.** In most cases, you have the right to inspect and receive a copy of the PHI that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I don't have you PHI, but I know who does, I will tell you how to get it. I will respond to your request within 30 days of received your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

If you request copies of your PHI, I will charge you not more than $0.25 per each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. **The Right to Receive a List of the Disclosures I have Made.** You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule;

disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before April 14, 2003.

I will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I may charge you a reasonable, cost-based fee for each additional request.

E. **The Right to Amend Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement within the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. **The Right to Receive a Paper Copy of this Notice**. You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

V. COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may 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. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: (909) 945-8894.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.