LUCY DANIELS CENTER
REGISTRATION INFORMATION

Family Information

Child:

Full name / Nickname _____ Gender _____

Date of birth / Place of birth _____

Resides with: _____

Parent / Guardian # 1:

Full name _____

Address/City/State/Zip _____

Telephone Numbers Home _____ Cell _____ Business _____

E-mail address _____

Social Security # _____

Date of birth / Place of birth _____

Occupation / Place of business _____

Parent / Guardian # 2:

Full name _____

Address/City/State/Zip _____

Telephone Numbers Home _____ Cell _____ Business _____

E-mail address _____

Social Security # _____

Date of birth / Place of birth _____

Occupation / Place of business _____

Sibling One:

Full name / Nickname _____ DOB _____ Gender _____

Sibling Two:

Full name / Nickname _____ DOB _____ Gender _____

Sibling Three:

Full name / Nickname _____ DOB _____ Gender _____

Lucy Daniels Center Consent to Release Personal and Medical information

Lucy Daniels Center
9003 Weston Pkwy Cary NC 27513
Office: 919-677-1400 Fax: 919-677-1489
www.Lucydanielscenter.org

Client's Name:_____ **DOB:** _____

Physician name and Group: _____**Phone#**_____

Address: _____

Is this the referring Pediatrician or Physician? Yes No

Pediatrician: It is customary for the Lucy Daniels Center to send a letter to your child's pediatrician(s) or family physician(s) to notify them that you have accessed services at our Center on your child's behalf, or to send them a report of your child's evaluation. We do this because your child's overall health care will benefit when your child's physician is knowledgeable about your child's emotional health.

LDC has permission to **release**❑ **Obtain** ❑ **Release and Obtain** ❑ **No Permission** ❑ information with my child's **Pediatrician**.

School or other source Name: _____**Phone #**_____
Address: _____
Did the school other source refer you to Lucy Daniels Center? Yes No

School or other source: It is often helpful for the Lucy Daniels Center to obtain information from your child's teacher(s), other school personnel or agency that has direct involvement with your child. On many occasions, it is helpful for LDC to obtain information from your child's school, after-school care provider or other source.

LDC has permission to **release** ❑ **Obtain** ❑ **Release and Obtain** ❑ **No Permission** ❑ information with my child's **School or other source**.(*Check one*) Other:_____

Description of Information to be Disclosed (Client should initial each item to be disclosed)

Assessment and Diagnosis❑ Psychological Testing ❑ Treatment Plan and Final summary ❑ Substance abuse ❑ HIV/aids information the purpose for the release of information is:

I understand that the information named in this consent will be used for the purposes of the evaluation and treatment of my child. My right to confidentiality has been explained to me and I understand what information will be released or obtained, the need for the information, and that State statutes and regulations protect the confidentiality of authorized information. I understand that I may revoke, in writing, this consent at any time except to the extent that action based on this consent already has been taken. This consent will expire 365 days after the date below. The authorization and request is fully understood and made voluntarily on my part. By signing below, I affirm that I am legally authorized to give consent on behalf of my child.

_____ _____ _____
Signature of legal guardian: Relationship to child Date:

Confidentiality and disclosure of information regarding substance use information is governed by and in accordance to the Code of Federal Regulations (42 CFR Part 2). In the event that a release of this type of information is needed, you will be asked to provide a separate consent form related to this disclosure.

Confidentiality and disclosure of information regarding HIV/AIDS information is governed by and in accordance of General Statute (GS) 130A-143. More information on this statute can be found at:
http://www.ncga.state.nc.us/enactedlegislation/statutes/pdf/bychapter/chapter_130a.pdf

Lucy Daniels Center Insurance Information

Client Name: _____ Date of Birth_____

POLICY HOLDER'S INFORMATION

Primary Insurance Company: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's Gender: Male ❑ Female ❑ Social Security #: _____

Policy ID# (if different from SSN):_____ Group Name: _____

Group number: _____ Mental Health Customer Service #: _____

Client's Relationship to Policy Holder: Self ❑ Spouse ❑ Child ❑ Other ❑ _____

Secondary Insurance Company (**if applicable**): _____

Policy Holder's Name: _____ _____ Policy Holder's Date of Birth: _____

Policy Holder's Gender: Male ❑ Female ❑ Social Security #: _____

Policy ID# (if different from SSN):_____ Group Name: _____

Group number: _____ Mental Health Customer Service #: _____

Client's Relationship to Policy Holder: Self ❑ Spouse ❑ Child ❑ Other ❑ _____

Client Has No Active Insurance ❑

We participate with some insurance plans. **We do not file claims to any insurance in which we do not participate.** Each insurance plan has different benefits for you as well as different financial obligations. Not all insurance policies cover all services. It is ultimately your responsibility to check with your insurance company to determine covered benefits. PLEASE REMEMBER: The agreement of the insurance carrier to pay for health care is a contract between you and the insurance company.

I authorize the disclosure of clinical and/or medical information necessary to process payment including but not exclusive to, commercial insurance companies, Medicaid, Health Choice and request payment of benefits to The Lucy Daniels Center. I request that payment for benefits be made on my behalf to The Lucy Daniels Center for any services furnished for me. I authorize release to the center for Medicaid and insurance companies and its agent of any medical information about me needed to determine or distribute these benefits for related services.

_____ _____

Signature of legal guardian Relationship to Child Date

Lucy Daniels Center Family Guidance Service Fee Agreement

CHILD'S NAME: _____ DOB: _____

Families are responsible for paying their full current financial obligation on each date of service. Please understand that we maintain this expectation under all circumstances without exception.

I: INSURANCE PROVIDERS: Lucy Daniels Center contracts with most major insurance providers. If you are covered by an insurance provider with whom we contract, you will be responsible for any deductible and co-payments required by your insurance provider. The Center will bill and collect payments from your insurance provider, and send you a monthly statement that summarizes all payments. You are responsible for full payment for uncovered services, including sessions beyond the limits covered by insurance providers.

We accept Medicaid for recipients who do not have other third-party coverage. We do not accept Medicaid for recipients who have other third-party coverage.

Occasionally we do not contract with a family's insurance provider. In that event, you would be responsible for the full payment of all fees at the time of service (see fee schedule.) The Lucy Daniels Center will submit claims to your insurance provider if you have out-of-network benefits, and reimburse you for payments that the Center may receive.

Families without health insurance or who choose not to use the insurance are responsible for all fees.
Families covered by Medicaid or North Carolina HealthChoice will not have any out-of-pocket financial obligation of any sort for any services, covered or uncovered.

II: NON-COVERED SERVICES (BY INSURANCE PROVIDERS)

Many services necessary to provide care for your child are "non-covered" by insurance providers.

- **Diagnostic Fee** ($150): On many occasions, we recommend that we conduct a diagnostic assessment on a child so that we can achieve a better understanding of the child's challenges and how to help. All evaluations (except those for families covered by Medicaid) will have a diagnostic fee of $150 that helps to cover our cost for many non-covered activities beyond the clinician's visits with parents and child. These non-covered services include: establishing the records and billing, communicating (administrator and/or clinician) with insurance provider, clinician reviewing records including developmental history, clinician contacting school or other professionals by phone or letter, clinician record keeping, and clinician phone conversations with parents. This Diagnostic Fee will always be part of any diagnostic evaluation, except for clients covered by Medicaid. The following non-covered fees may or may not be a part of any particular evaluation:
- **School observation** ($150): Provided by a Lucy Daniels Center child development specialist, including approximately one hour observation, travel time, report generation, and consultation with clinician.
- **School consultations** ($150/hr.): Any conference or consultation with school personnel, in person or by telephone, including travel time.

Although you can expect that the diagnostic fee, school observation, and school consultation will not be covered services by your insurance company, there are rare exceptions, and we will inform you in those instances.

III: PSYCHOLOGICAL TESTS

There are occasions when we recommend that we administer and interpret psychological tests. These tests are provided by our psychological staff. These are generally covered, at least to some degree, by health insurance. There is a great deal of variability with regard to out-of pocket expense for psychological testing, depending upon an individual's insurance coverage and the particular testing required. We will provide information about the expense of the recommended testing before we begin the testing so that you would know the estimated expense.

Lucy Daniels Center Family Guidance Service Fee Agreement (continued)

III: UNDISCOUNTED FEE SCHEDULE

The Lucy Daniels Center undiscounted fee schedule applies to families who are in the deductible period, who are not using insurance with an insurance provider with whom Lucy Daniels Center contracts, or who are paying out of pocket. Although we accept contracted (discounted) amounts with providers with whom we have contracted as full payment due (in addition to the co-payments) *for covered services*, our statements to the insurance providers will generally show our full, undiscounted fee.

- **For most types of sessions, our undiscounted fee is:**
- **Clinical Social Worker (L.C.S.W.): $125.00/45-50 minute session**
- **Psychologist (Ph.D. or Psy.D.): $150/45-50 minute session**
- **Psychiatrist (M.D.): $150 – $250/ 45-50 minute session**

V: ADDITIONAL POLICIES

- Account must be paid in full at each visit with cash or checks only (HSA checks welcomed), **credit cards are not accepted.** Checks made payable to **Lucy Daniels Center**. An administrative fee of $35 may apply on each occasion that account is not paid in full.
- Statements will be mailed or emailed monthly. Balances that are shown on the statements may change subject to the resolution of insurance claims.
- We charge a $25.00 fee for checks returned for non-payment for any reason.
- We have a sliding scale fee (need based fee reduction) for qualifying families who do not have insurance coverage.
- We ask that you make every effort to keep appointments. **We charge a $50.00 fee for appointments that are cancelled. These sessions cannot be submitted for insurance reimbursement.**
- There are two circumstances under which we will waive the cancellation fee:
- Grace period: We will waive the fee if the appointment is cancelled no later than 48 before the time of the appointment.
- Illness: On an honor system, parents will not be charged for appointments that are canceled because of illness on the part of parent or child, up to the time that the appointment is scheduled to begin. Please cancel a session when your child has any symptoms that we describe in our guidelines. The session must be canceled in advance of the session time in order for the cancellation fee to be waived.

There are absolutely no exceptions to this policy. We understand that conflicts will come up that will make it difficult or impossible for you to keep an appointment. Nevertheless, we will charge under any and all circumstances, other than the exceptions described above. Our staff does not have the discretion to make exceptions to this policy. Our $50.00 fee for cancellations is a compromise amount that takes into account the possibility that the cancellation was unavoidable and that we cannot use that cancelled hour for revenue generation. The fee for a missed session is due at the time of the next appointment in accordance with our policy that your account is paid in full at the time of each session.

I have read and agree to the provisions of the Lucy Daniels Center fee policies as described above

_____		_____
Signature of legal guardian	Relationship to Child	Date
_____		_____
Signature of legal guardian	Relationship to Child	Date

Lucy Daniels Center Family Guidance Service Communications

From time to time the Lucy Daniels Center for Early Childhood sends communications like newsletters, e-newsletters, and invitations to Center events to our clients, alumni, volunteers, friends and supporters. With your permission, we would like to include you in these mailings. Each mailing will provide an opportunity to cancel future mailings, if for any reason you decide that you no longer want to receive the communications.

- I **would like** to receive Center communications ❑
- I prefer **not to** receive Center communications ❑

The Lucy Daniels Center also makes grant applications to major employers in the Triangle area. In many cases they ask us to provide names of clients and/or volunteers who are affiliated with the Center and employed by them. We are committed to preserving the confidentiality of your consultation, and our solution is to provide information to these employers in a **statistica**l form. This information will be reported only in a numerical and aggregate form: for example, we might report to Cisco that we have four Cisco parents of students and/or clients affiliated with the Center. (No other information will be provided.) Please let us know if you give your permission to be represented on these grant applications.

- **I give** the Lucy Daniels Center for Early Childhood permission to report to my or my spouse's employer as part of a grant application process from the Center that my child/children have been served by the Lucy Daniels Center for Early Childhood ❑
- I prefer **not** to be represented ❑

Your permission will be for this restricted use only. For your information, whether you provide this permission or not, the Center will never sell or trade your name and address information with any other organization.

_____

Print legal Guardian's Name/s E-mail address

_____

Legal Guardian's Signature/s Relationship to Child Date

Lucy Daniels Center Statements of Account

We provide our statements of your account by email. Please provide each parent's email address below in order to receive your monthly account statement. If you should change your email address at any point, please inform our office immediately. Only one name and email is necessary.

Parent/Guardian (1) Name _____

Parent/Guardian (1) Email _____

Parent/Guardian (2) Name _____

Parent/Guardian (2) Email _____

Dear Parent(s):
Individuals, corporations, foundations and others in our community generously provide charitable funds that help support the Lucy Daniels Center because the combined payments from parents and insurers generally do not cover the full cost of the quality care that we provide. Charitable funders often request information about the population we serve. We sincerely request your help so that we can provide this information. Your participation is entirely optional. Your information will not be identifiable in any way, including to Lucy Daniels Center staff. Thank you for taking a few extra minutes to provide this information.

1. **Birth Year of Child:** _____

2. **Number of household members:** □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 or more
3. **Gender of child:** □ Female □ Male
4. **Heritage (check all that apply):**
   □ White □ African American □ Hispanic □ East Asian □ South Asian
   □ Native American □ African □ Multicultural □ Other

5. **City and County:** _____
6. **Zip Code:** _____
7. **Total household income (Gross unadjusted salaries before deductions):**
   □ Under $30,000 □ $30,000 – $49,999 □ $50,000 – $75,000
   □ $75,000 – $100,000 □ over $100,000

8. **Qualify for free/reduced lunch:** □ yes □ no/don't know

9. **Please indicate how you decided to consult the Lucy Daniels Center (check more than one if appropriate):**
   □ Recommendation from pediatrician
   □ Recommendation from mental health professional
   □ Recommendation from childcare professional
   □ Recommendation from teacher in kindergarten, elementary or middle school
   □ Recommendation from another organization (specify)
   _____
   □ Recommendation from prior client of Lucy Daniels Center
   □ Recommendation from friend
   □ Recommendation from insurance company or insurance panel list
   □ Website
   □ Carolina Parent articles
   □ Media Source other than Carolina Parent
   □ Lucy's Book Club
   □ Other (specify) _____

Lucy Daniels Center Consent for Evaluation and Treatment

CHILD'S NAME: _____ DOB: _____

I voluntarily consent that I will participate in a mental health evaluation and/or treatment at the Lucy Daniels Center. I understand that complete and accurate information will be provided concerning the Center's professional judgments about each of the following areas for my child:

■The benefits of the proposed treatment ■ Alternative treatment modes and services ■ Manner in which treatment will be provided ■ Possible adverse effects from the treatment if any ■ Implications of declining treatment

The evaluation or treatment will be conducted by a licensed mental health clinician in the state of North Carolina. Provisionally licensed clinicians will be supervised by a staff licensed clinician. Evaluation and treatment can include diagnostic interviews with parents, children; psychological testing; psychiatric evaluation and medication management; parent counseling; home visits; consultation with schools or with other professionals involved in the child's care; psychotherapy with child or with family units; and day treatment.

Appointments are set directly with clinicians. We realize illness and other factors arise that can adversely affect the keeping of an appointment. However, should a pattern of cancelling or not showing for scheduled appointments persists without resolution; the treating clinician reserves the right to refuse treatment.

Benefits and Risks to Evaluation/Treatment: Possible benefits to treatment include decrease in child's symptoms, enhancement of social and academic functioning, improvement in family relationships and quality of life, and increased awareness of strengths and limitations. In general, there is little risk in evaluation/treatment, however, because it often involves discussing or confronting painful feelings and experiences, children or parents may feel emotionally uncomfortable at times. Additionally, there are potential side effects of the use of medications. You have the right to refuse any treatment recommendation.

Emergency Services: Lucy Daniels Center provides clinical services during usual business hours, Monday through Friday (8:30 – 4:30 pm), with the exception of selected holidays during which the Center is closed. With the exception of provisions for Medicaid clients, the Center does not provide after hours or weekend services.

> **For all families other than those covered by Medicaid:** In the event of an urgent situation during usual working hours (Monday – Friday, 8:30AM – 4:30 PM, other than LDC holiday days), please call the Center at 919 677-1400 and leave a voice mail for your clinician. Alternatively, if the situation requires immediate response, please so indicate to the receptionist or other Lucy Daniels Center personnel who will inform your clinician immediately. If your clinician is unable to respond for some reason in a suitable timeframe, or if the emergency occurs outside of working hours, please call 911 or consult one of the resources listed below.
>
> **For all families covered by Medicaid:** Lucy Daniels Center provides a 24 hour/7 day a week service for emergencies of families currently in treatment with a clinician from our Center and whom are covered by Medicaid. The service is solely for the purpose of assisting with emergency situations that involve threats to life or health, and is not for the purpose of providing counseling for otherwise difficult situations. If a life or health threatening situation arises during business hours (Monday – Friday, 8:30AM – 4:30 PM, other than LDC holiday days), please call the Center at 919 677-1400 and leave a voice mail for your clinician. Alternatively, if the situation requires immediate response, please so indicate to the receptionist or other Lucy Daniels Center personnel who will inform your clinician immediately. If your clinician is unable to respond for some reason in a suitable timeframe, or if the emergency occurs outside of working hours, please call 911 or consult one of the resources listed below. If a life or health threatening situation occurs after business hours, please call 919 624-4190. This line will rotate among staff. In the event that you cannot reach a clinician in a timely enough way after hours, we recommend that you consult one of the resources listed below.
>
> ■Holly Hill Hospital 24 hour hotline 919 250-7000 ■ Therapeutic Alternatives Mobile Crisis Team 877 626-1772
>
> ■ Wake Crisis and Assessment Services 919 250-12160 ■ Local Emergency Room

In situations involving mutually agreed upon urgent services, your clinician will do their best to talk with you by phone, or when possible, schedule an appointment for you within 48 hours of your request. This will be dependent on the availability of your clinician. It is also our intention to respond directly to requests for consultations within 14 days of the initial request.

By signing below, you are consenting for treatment on behalf of your child. You may withdraw this consent for treatment at any time.

_____ _____ _____

Signature of legal guardian Relationship to Child Date

_____ _____

Lucy Daniels Center Representative Date

In the state of N.C., basic human rights are defined to be the right to dignity, privacy and humane care. In addition to these basic human rights, when you are receiving publicly funded MH/IDD/SA services, you have the right to:

- Privacy and the expectation that your personal information will be kept confidential •Review your medical record •Receive care in the least restrictive environment suitable to meet your needs •Be informed in advance of potential risks and benefits of treatment and to consent to or refuse these services, and the right to treatment including access to medical care and habilitation services, regardless of age or degree of MH/IDD/SA disability •Participate in the development of an individualized, person-centered treatment or service plan •Be free from mental and physical abuse, neglect and exploitation •Be free from unwarranted invasion of privacy •Be free from the threat or fear of unwarranted suspension or expulsion from services •File a complaint or grievance if you have concerns that we cannot resolve together. You may file a grievance with the offices below:

Handling Concerns: The Lucy Daniels Center is committed to offering excellent services for each child and parent. It is important that parents bring up any concerns that arise with the person most directly involved in a timely manner. Your next step would be to discuss the situation with the Clinical Director; if the Clinical Director is part of the concern to be addressed, the Associate Director will appoint a substitute. If the problem cannot be satisfactorily resolved within 30 days, you are welcome to contact:

Advocacy & Customer Service Section - Division of MH/DD/SAS
Customer Service and Community Rights Team
919-715-3197 / 1-855-262-1946 or
Email: dmh.advocacy@dhhs.nc.gov

Disability Rights NC
3724 National Drive, Ste 100 Raleigh, NC 27612
877-235-4210 /919-856-2195
TTY: 888-268-5535 /Fax: 919-856-2244
www.disabilityrightsnc.org

This statewide agency is designated under federal and state law to protect and advocate for the rights of persons who have disabilities.

Treatment Plan: Within the parameters of my child's right to confidentiality, parents may obtain information regarding the progress and outcome of the above-named services by contacting child's therapist and requesting a copy of the parent or guardian signed treatment plan. If you wish to have a copy of your child's treatment plan, please make this request directly to your treating therapist and a copy will be provided to you.
At the Lucy Daniels Center, treatments are highly individualized and many matters are discussed and worked through within the therapeutic treatment relationship. However, there are a few global expectations for families receiving treatment at the Center and which are outlined below:

1. **Parental presence**: Parents, guardians, or caretakers are expected to remain on the Lucy Daniels Center premise for the duration of the time that a child is in their individual psychotherapy session. If you are unable, for any number of reasons, to make the necessary arrangements for this, your therapist will likely request that the session be rescheduled.

2. **Child supervision:** Children are to be under the care and supervision of a parent, guardian, or caretaker at all times and are not permitted to be unattended in the lobby or other areas of the building during evaluation or parent guidance sessions. If you are unable, for any number of reasons, to make necessary arrangements for this, your therapist will likely request that the session be rescheduled. It is possible that a late cancellation fee will be applied to this missed session if unable to be rescheduled.

3. **Weapons:** Under no circumstances are weapons, such as but not limited to knives and firearms, permitted in or near the Lucy Daniels Center. If it is discovered that you have a weapon, you will be asked to put away the weapon and leave the premise. If necessary, law enforcement will be contacted.

4. **Missed appointments:** It is understandable that there are occasional and unexpected circumstances that require missed or cancelled appointments. However, if you have missed 3 or more consecutive scheduled sessions, your clinician will notify you by phone or mail. Termination of treatment is at the discretion of your clinician. We encourage you to talk with
your clinician about the circumstances related to the missed appointments so that a plan for the best next steps can be made. In the event that you decide to terminate your treatment, you are welcome to return to the Lucy Daniels Center at any time in the future by contacting your therapist directly or by completing our Request for Consultation located on our website www.lucydanielscenter.org

Consent: I understand that I may revoke, in writing, this consent at any time except to the extent that action based on this consent already has been taken. This consent will expire 365 days after the date below. This authorization and request is fully understood and made voluntarily on my part. By signing below, I affirm I am legally authorized to give consent on behalf of my child. In cases of shared legal custody or in the absence of documentation regarding custody, consent to evaluate and provide treatment will be provided by both parents.

Lucy Daniels Center Notice of Privacy Practices

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

Your or your child's health record contains personal information about you, your child and his or her health. This information that may identify you and that relates to you or your child's past, present or future physical or mental health or condition or health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your healthcare treatment and related services. This includes consultations with clinical supervisors or other treatment team members.

For Payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for your insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it became necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI, in our judgment, is necessary for collection.

For Healthcare Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities.

Required by Law: Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization:. There are a limited number of situations as detailed under HIPAA regulations 45 CFR 164.512 that applicable law and ethical standards permit us to disclose information about you or your child without your authorization. Specific criteria for such unauthorized releases can be obtained under the above noted regulations.

Examples of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as social work licensing board or the health department)

- Required by a Court Order

- Necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With authorization: Uses and discloses not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Your Rights regarding your PHI

You have the following rights regarding your PHI that we maintain about you. To exercise any of these rights, please submit your request to our Privacy Officer at Family Guidance Service at Lucy Daniels Center.

- Right of Access to Inspect and copy: You have the right, which may be restricted only in exceptional circumstances to inspect and copy PHI that may be used to make decisions about you or your child's care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or your child. We may charge a reasonable cost based fee for copies.

- Right to Amend: If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.

- Right to an Accounting of Disclosures: You have the right to request an accounting of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12 month period.

- Right to Request Restrictions: You have the right to request a restriction or limitation on the use or disclosure of your or your child's PHI for treatment, payment or health care operations. We are not required to agree to your request.

- Right to Request Confidential Communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

Lucy Daniels Center

This form is used to document an individual's acknowledgement of receipt of our Privacy Practices Notice & Patient Rights and Emergency Medical care.

Acknowledgement of receipt of notice of Privacy Practices

_____

Child Name DOB

_____

Legal Guardian's Name Relationship to child

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual

(power of attorney, healthcare surrogate, etc.)_____

_____ _____

Signature of LDC Staff Member Date:

If staff member has not been possible to obtain a signed acknowledgement, please explain efforts to obtain:

Patient Rights Information

By signing below, you are acknowledging you are aware of your client rights and responsibilities.

_____ _____

Signature of legal guardian Relationship to Child Date

_____ _____

Lucy Daniels Center Representative Date

Emergency Medical Care

I also recognize that in extremely rare circumstances I may be in need of emergency medical care and unable to provide immediate consent for release of information. Should such an unlikely situation arise, I give my permission for information to be released about me or my child's condition or situation to anyone providing medical assistance.

_____ _____

Signature of legal guardian Relationship to Child Date

_____ _____

Lucy Daniels Center Representative Date

You have the right to a copy of this notice