PSYCHIATRIC SERVICES, P.C.

Robert Dale Jones, M.D. emeritus
Sarah L. Jones, M.D. emeritus
Michael J. Sedlacek, M.D.
Janet P. McGivern, M.D.
Cheryl J. Buda, M.D.
Brian Lubberstedt, M.D.
Julie A. Dickson, M.D.
Spencer M. Gallner, M.D.
Todd K. McKee, Ph.D.

CENTER POINTE BUILDING
9239 W. Center Road, Suite 211
Omaha, NE 68124-1900

Telephone: (402) 399-9305
Fax: (402) 397-3191
www.psychiatricservicespc.com

Dear________________________________

Your appointment information:

Date:________________________________

Time:________________________________

Physician:____________________________

Welcome to Psychiatric Services, PC. We appreciate that you have selected our practice to provide your medical services. The relationship between physician and a patient is very important: we have designed every aspect of our practice to provide the best care possible.

Enclosed you will find pre-registration and medical history forms as well as other vital information. To expedite your first visit we ask that you complete all of the forms **prior** to your first visit, arrive 15 minutes early to allow enough time to ensure forms are complete, scan your medical insurance card and take a quick picture for your chart. Please be sure to list all your medications on the attached sheet. If you have any questions regarding these forms do not hesitate to contact our office.

If you for any reason are unable to keep your appointment, please contact our office at 402-399-9305 to reschedule your appointment.

Sincerely,

The Physicians and Staff of Psychiatric Services, PC.

PSYCHIATRIC SERVICES, P.C.

FORMS CAN BE COMPLETED ON OUR WEBSITE **www.psychiatricservicespc.com**

Where options are listed please **circle only one answer**.

Date of Appointment	Reason for Appointment	Appointment With O O O O O O O Sedlacek / McGivern / Buda / Lubberstedt / Dickson / Gallner / McKee

Referring Physician	Family Physician (if different than Referring Dr)

Pharmacy Name	Pharmacy Address, City, State, Zip Code	Pharmacy Phone #

Patient's Name: First Name, Middle Initial, Last Name (please print)	Goes By	Sex O O M / F	Date of Birth	Age	Soc. Sec. #

Race: White-Caucasian O Black-African-American O American Indian-Alaska Native O Asian O Nat. Hawaiian-Pacific Islander O Declined O Unknown O Other:________________

Ethnicity: Declined O Hispanic-Latino O Not Hispanic-Latino O

Primary Language: English O Spanish O Arabic O Chinese O Filipino O French O German O Greek O Hindi O Hmong O Italian O Japanese O Korean O Lithuanian O Polish O Portuguese O Russian O Somali O Vietnamese O Declined O N/A O Other:________________

Religion: Buddhist O Catholic O Hindu O Islam O Jehovah's Witness O Jewish O Mormon O Protestant-Methodist O Lutheran O Baptist O N/A O Unknown O

Marital Status: Single O Married O Separated O Divorced O Widowed O Annulled O Common Law O Domestic Partner O Living Together O Other O

Street Address (include apt#)	City, State and Zip Code +4 digits

Home Phone #	Work Phone # (include ext.)	Cell Phone #	Primary Phone # Home O Work O Cell O

Fax #	Pager #	Email Address

EMPLOYMENT INFORMATION

Patient's Employer	Status: Full-time O Part-time O Self-employed O Retired O Unemployed O Temporary Unemployed O Leave of Absence O Contract O Active Military Duty O Part-time Student O Full-time Student O Other O

Employer's Street Address	City, State and Zip Code	Occupation (indicate if student)

EMERGENCY CONTACT INFORMATION

1st Emergency Contact (First Name, M.I., Last Name)	Relationship	Date of Birth	Cell Phone #

Emergency Contact's Employer	Occupation (indicate if student)	Work Phone #

2nd Emergency Contact (First Name, M.I., Last Name)	Relationship	Date of Birth	Cell Phone #

INSURANCE INFORMATION

Person Responsible for Payment (if not the patient)	Street Address, City, State and Zip Code

Primary Insurance	Policyholder's Name	Relationship	Date of Birth
Secondary Insurance	Policyholder's Name	Relationship	Date of Birth

ALL INSURANCE COPAYS ARE TO BE PAID AT TIME OF SERVICE.

All professional service rendered are charged to the patient. Our office will complete the necessary forms to help expedite insurance payments. However, the patient is responsible for all fees regardless of insurance coverage including denied or non-covered services by Medicare, Medicaid and Medicaid Managed Care Plans.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policyholder________________________________

I hereby assign payment directly to Psychiatric Services PC any medical benefits for professional services rendered. I understand that I am financially responsible for my deductible, coinsurance, copayments, services received without prior authorization and any allowable charges by my insurance company/companies. I also authorize the release of information to another physician, hospital or insurance company as may be necessary for further treatment or determination of benefits and payments.

Patient Signature **X** ________________________________ Date ____________________

Personal Representative Signature **X** ________________________ Date ____________________

Relationship to Patient________________________________

Name ________________________________ Date ____________________

FAMILY HISTORY

Spouse Name ________________________________ Years Married ____________________

Children's Names and Ages ____

____

Were you raised by: Both Parents? __________ Single Parent? __________ Relative? __________ Other? __________

Father's Name/Occupation ____

Mother's Name/Occupation ____

Brothers/Sisters in birth order: (Include Ages) ________________________________

Family History of: (who, what)

Alcoholism or Substance Abuse? ____

Mental Illness? ____

Prolonged Physical Illness? ____

Your Education: Highest Degree: ____________________ Field of Study: ____________________

I, or ____________________, will be responsible for any charges for evaluation or treatment by Drs. Michael J. Sedlacek, Janet P. McGivern, Cheryl J. Buda, Brian Lubberstedt, Julie A. Dickson, Spencer M. Gallner, Todd K. McKee, and his/her associates in this office. I understand that I am responsible for payment for consultation not canceled 24 hours in advance. I understand that payment if charges incurred is due at the time of service, unless other definite financial arrangements have been made prior to treatment. I hereby authorize the clinician to furnish information to insurance carriers concerning my treatment. I understand that I am responsible for all payments. Any monies received by the clinician from above insurance companies, over and above my indebtedness, will be refunded to me when my bill is paid in full. I understand any returned checks will subject me to a $25.00 returned check charge.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

Patient's Signature ________________________________ Date ____________________

Parent/Guardian's Signature ________________________________ Date ____________________

We will be happy to file your insurance claim, but your co-payment and/or your portion of the bill is expected at the time of service. We will be happy to discuss fees, schedule of payment, or any other question relating to billing or insurance.

ACKNOWLEDGEMENT OF PRIVACY NOTICE

The undersigned hereby acknowledges receipt of the Notice of Privacy Practices of Psychiatric Services, PC.

Signature ________________________________ Date ____________________

Print name ________________________________

Name ______________________ Date ______________________

MEDICAL INFORMATION

What is the reason you are seeking help at this time? ______________________

Over the last 2 weeks, how often have you been bothered by the following symptoms?	**Not at all**	**Several days**	**More than half of the days**	**Nearly every day**
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling asleep, staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself, or that you are a failure to have let others down				
7. Trouble concentrating on things				
8. Moving or speaking so slowly that other people could have noticed, or being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead or of hurting yourself.				
10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people.	☐ **Not difficult at all**	☐ **Somewhat difficult**	☐ **Very difficult**	☐ **Extremely difficult**

11. Has there ever been a period of time when you were not your usual self and ...	**Yes**	**No**
... you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?		
... you were so irritable that you shouted at people or started fights or arguments?		
... you felt much more self-confident than usual?		
... you got much less sleep than usual and found that you didn't really miss it?		
... you were more talkative or spoke much faster than usual?		
... thoughts raced through your head or you couldn't slow your mind down?		
... You were so easily distracted by things around you that you had trouble concentrating or staying on track?		
... You had much more energy than usual?		
... you were much more active or did many more things than usual?		
... you were much more social or outgoing than usual: for example, you telephone friends in the middle of the night?		
... you were much more interested in sex than usual?		
... you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
... spending money got you or your family into trouble?		
If you checked Yes to more than one of the above, have several of these ever happened during the same period of time?		
How much of a problem did any of these cause you (like being unable to work: having family, money, or legal troubles: and/or getting into arguments or fights)? ☐ **No Problem** ☐ **Minor Problem** ☐ **Moderate Problem** ☐ **Serious Problem**		

	Yes	**No**
Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?		
Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?		

Name ______________________________ Date ______________

Please circle the items which apply to you in the last 6 months:

Weight gain or loss ☐ Binge or purge ☐ Worried about your weight or appearance ☐ Poor motivation ☐
Anxious or nervous ☐ Panic ☐ Crying spells ☐ Restlessness/difficulty sitting still ☐ Anger ☐
Recurrent thoughts or actions ☐ Sexual problems ☐ Hearing or seeing things ☐ Confusion ☐
Thoughts of self-harm ☐ Thoughts of suicide ☐ Forgetful or memory problems ☐ Nightmares ☐
Difficulty being in public ☐ No memory for certain period of time ☐

Are any of these symptoms worse at any time of the day, month, or year? ☐ Yes ☐ No
Have you ever had counseling/therapy or medication for any of the above? ☐ Yes ☐ No
If Yes - where, when and from whom? ______________________________
Previous Hospitalizations for substance abuse, alcoholism, eating disorders, or other psychiatric disorders? ☐ Yes ☐ No
Details: ______________________________
Do you drink alcohol? ☐ Yes ☐ No How many times a week? ________ How many drinks per time? ________
Do you use nicotine? ☐ Yes ☐ No Do you use caffeine? ☐ Yes ☐ No
Do you currently use illicit drugs? ☐ Yes ☐ No Have you ever abused prescription or illicit drugs? ☐ Yes ☐ No
Do you exercise regularly ☐ Yes ☐ No Do you gamble? ☐ Yes ☐ No
What is your Height? ________ Weight? ________
List all medication allergies: ______________________________

Current Medical Conditions and Medications: **Primary Care Dr:** ____________ **Last exam date:** ________

Condition	Medication/Supplement	Amount	When Prescribed

Circle other medical conditions: thyroid disease cancer kidney disease high blood pressure irregular heart beat/pacemaker falling loss of consciousness liver disease chest pain heart attack high cholesterol headaches osteoporosis asthma/COPD stroke HIV/AIDS hepatitis stomach ulcer arthritis congestive heart disease

Circle all current positive findings:

Constitutional: wt loss fever chills
Eyes: blurry vision dry eyes double vision
ENT: hoarseness hearing loss nose bleeds swallowing problems
Cardiovascular: chest pain palpitations swelling of legs or feet
Respiratory: short of breath cough
Gastrointestinal: nausea vomiting diarrhea constipation pain
Genitorurinary: increased urinary frequency incontinence

Skin: rash hives hair loss itching
Musculoskeletal: joint pain muscle aches muscles weakness back pain
Endocrine: increased thirst excessive sweating heat/cold intolerance
Neurological: seizures tremors headaches/migraines loss of balance dizziness
Hem/Lymphatic: easy bruising swollen lymph nodes
Allergic/Immunologic: allergic reactions hay fever frequent infections

PERSONAL MEDICATION FORM

Name:______________________________ Date of Birth:____________ Date form last updated____________

Your complete medication history is important to your physicians. Please fill out this form and bring it with you. If for some reason you are unable to fill out this form, please bring in a bag of all of the medications (in their original containers) that you are currently taking.

Allergies: Are you allergic to medications, iodine, food, tape, or latex?
List each substance you are allergic to and the reaction you experienced.

Allergy	Reaction	Allergy	Reaction

Vaccines: Check one box for each vaccine.

Tetanus	Pneumonia	Influenza (Flu)	Pediatric (or child)
☐ Within past 10 years ☐ Unknown	☐ Within past 5 years ☐ Unknown	☐ Within the past year ☐ Unknown	☐ Up-to-Date ☐ Unknown

Medications: Please list all prescription and non-prescription medications, herbals, eye drops, nutritional supplements, inhalers, etc. that you use.

Name of Medicine	Dose (mg. units, puffs).	Route (by mouth, eye drops)	Directions	Purpose Why do you take it?

Personal Medication Form continued

Name of Medicine	Dose (mg. units, puffs).	Route (by mouth, eye drops)	Directions	Purpose Why do you take it?

Past Surgeries (Operations)	Year

Contact Information:

Doctor's name:______________________________________ **Dr. Phone:** (____) ____________________

Pharmacy name:_____________________________________ **Pharmacy phone:** (____)________________

Emergency contact: Name: ______________________________ **Phone:** (____)____________________

POS Reorder # 1615023

PSYCHIATRIC SERVICES, P.C.

Robert Dale Jones, M.D. emeritus
Sarah L. Jones, M.D. emeritus
Michael J. Sedlacek, M.D.
Janet P. McGivern, M.D.
Cheryl J. Buda, M.D.
Brian Lubberstedt, M.D.
Julie A. Dickson, M.D.
Spencer M. Gallner, M.D.
Todd K. McKee, Ph.D.

CENTER POINTE BUILDING
9239 W. Center Road, Suite 211
Omaha, NE 68124-1900

Telephone: (402) 399-9305
Fax: (402) 397-3191
www.psychiatricservicespc.com

TREATMENT AGREEMENT

- I consent to the care and treatment for myself with Drs. Sedlacek, McGivern, Buda, Lubberstedt, Dickson, Gallner, McKee and their associates.
- I understand that I am financially responsible for all charges incurred for the services received from the above providers, regardless of insurance coverage. This includes, but is not limited to charges that are denied for pre-existing conditions, usual and customary allowances, and charges not allowed / covered by the insurer. Because of the growing number of different insurance policies, it is my responsibility to check and become familiar with my mental health benefits. Furthermore, if my managed care plan requires precertification, I realize it is my responsibility to precertify my first visit and present my authorization number at the time of my first visit. I understand the business office will cooperate with my insurance company, but that it is my responsibility to contact my insurance carrier to meet any additional requirements for pre-certifications that are not listed above.
- I have been informed that my insurance company may request copies of my medical records be faxed in order to make payment or authorize further visits. My signature below gives my permission to release this information and to fax medical records when requested.
- I understand the physician/therapist cannot render services on my behalf on the assumption that the charges will be paid by my insurance carrier. I further understand that in the event of non-payment by my insurance carrier for any reason I agree to be personally responsible for the balance. In the event of non-payment, my account may be assigned or referred to a collection agency for collections.
- I understand and agree to the terms of the Credit Policy as outlined below:
  Payment is expected in full within 30 days from your statement date. Limited exceptions may be allowed but only if prearranged. My copayment, coinsurance and any deductible is expected at the time of service.
- I am aware that the effectiveness of the treatment reviewed with me depends upon my commitment to the program and follow through with scheduled appointments. If I do not give 24 hours notice of cancellation there will be a charge for that missed appointment. Also, if repeated appointments are missed this may result in termination of care from this office and/or referral to another provider.
- I agree to provide timely notification to Psychiatric Services, PC of any changes in address, guarantor status, employment, and insurance coverage.
- I understand that I may use my VISA, Mastercard, Discover, American Express or bank debit card to pay for my services.
- I understand it may be necessary from time to time for the office to contact me by telephone. If I cannot be reached, I understand the office policy is to leave a discreet message on my answering machine or voice mail, or with whomever answers the telephone on my behalf. I agree to hold the office harmless for all such disclosures in compliance with this policy.
- No recording of any patient sessions shall be allowed and no recording devices of any kind shall be brought by a patient to a session.
- My signature below indicates I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

____

Signature of Patient and/or legal guardian

Date________________________ Witness____________________________

PATIENT'S PERMISSION TO DISCLOSE INFORMATION

At Psychiatric Services, PC, we are committed to treating and using protected health information about you responsibly. Below are listed ways in which your personal information may be used. We ask that you *read the following carefully.* Please check the lines to indicate your permission.

Telephone messages: At times, Psychiatric Services, PC, may need to contact you by phone. We also make appointment reminder calls. Please indicate if we may leave detailed messages and/or reminder calls on:

Home phone/cell phone:
______ Answering machine/voice mail
______ With a family member
OR
______ Leave callback number only

Work phone:
______ Answering machine/voice mail
OR
______ Leave callback number only

Written communication:
______ You may send mail (medical records, prescriptions, and or any other health information) to:
______ My home address
______ My work address
______ You may communicate with me by fax at this number:____

Please check the following for which you give permission:
______ If my spouse calls Psychiatric Services, PC, requesting information in regard to my appointments or billing.
______ If a family member calls Psychiatric Services, PC, requesting information in regard to appointments or billing.
______ My Power of Attorney may need to be present at time of examination, may need to telephone or write Psychiatric Services, PC, for information regarding my health, appointments or billing.
______ If I have someone accompany me into the doctor's or therapist's office, I give permission for the doctor or therapist to discuss my case, test results, or any other health information in the person's presence.
______ I give permission to Psychiatric Services, PC, to allow someone other than myself to pick up my medication.

Signature ____ Date ______________________

Please print name ____

Unless otherwise noted, this release will remain in effect until the patient's treatment is completed.

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Patient Name: ____________________ DOB: ____________________

Address: ____

I hereby

______ Do

______ Do NOT

give my informed consent for (please circle)

Janet P. McGivern, M.D. O　　Michael J. Sedlacek, M.D. O

Cheryl J. Buda, M.D. O　　Brian Lubberstedt, M.D. O

Julie A. Dickson, M.D. O　　Spencer M. Gallner, M.D. O

Todd K. McKee, Ph.D. O

regarding my treatment to speak with or send documentation to my

Primary Care Physician ____
Name

____
Street Address

____
Telephone Number　　Fax Number

I understand my records are protected under Federal Regulation 42 CFR, Confidentiality of Alcohol and Drug abuse and under the general laws of my state. They cannot be re-disclosed without my written consent, except as specially stated by law.

I understand I am authorizing the release of confidential information which is to be used in conjunction with the profession services I am receiving.

I understand this authorization shall remain in effect until otherwise withdrawn or cancelled by me in writing. A copy of this authorization is as good as the original.

Signature ____________________ Date ____________________

Witness ____________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION.
PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on **4-2013** and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, **Sharrie Dye, CMM**.
Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $.50 for each page and the staff time charged will be $20 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)
We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form/ format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be **$.50** for each page and the staff time charged will be **$20** per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

Practice Name: **Psychiatric Services, PC** Privacy Officer: **Sharrie Dye, CMM**

Telephone: **402-399-9305 ext 111** Fax: **402-397-3191**

Email: **sdye@pspc.omhcoxmail.com**

Address: **9239 W. Center Rd., Ste 211, Omaha NE 68124-1900**

HIPAA Notice of Privacy Practices 2013

This form does not constitute legal advice and covers only federal, not state law.

DIRECTIONS TO:

PSYCHIATRIC SERVICES, P.C.

CENTER POINTE BUILDING
9239 W. Center Road, Suite 211
Omaha, NE 68124-1900
www.psychiatricservicespc.com

From Interstate 680 — take Center Street east approximately 1½ miles to stoplight at Paddock Road. Turn right (south) curving down the road to the glass and brick building called Center Pointe Building on the right (just before Earl May Nursery).

OR

From Interstate 80 — take 84th Street exit heading north approximately 1 mile to Center Street. Turn left (west) on Center Street. After passing through the 90th and Center Street Intersection, move to the left lane to turn left at the light at Paddock Road. You will curve down the road to the glass and brick building called Center Pointe Building on the right (just before Earl May Nursery).

THEN

Entering the north doors, take the elevator to the second floor.

Turn left after exiting the elevator and another immediate left at the end of the hall.

Our reception area/window is straight ahead. Our physicians' names are on the wall.