Caroline B. Williams, PhD, MP *Prescribing Clinical Psychologist*
2204 Brothers Rd., Suite B, Santa Fe, NM 87505 *(ph)505-819-0859 (fax) 505-570-4560*

To new patients:

Welcome to Dr. Caroline Williams' mental health practice. We are looking forward to meeting you at your first appointment. The attached packet includes paperwork that can help the beginning of your treatment relationship with Dr. Williams flow more smoothly. It includes:

1) Identifying information and insurance information.
2) Explanation of office policies and procedures.
3) Medical and social history information.

Mental health practices have more stringent confidentiality regulations than most other types of doctors you have seen. The office policies section explains these for you.

The medical and social history forms may seem lengthy. Keep in mind that the more historical information you include in the forms ahead of time, the more time Dr. Williams can spend addressing your present concerns during the first appointment. If you have any questions as you go through the paperwork, let us know when you arrive and we will explain things.

We intend for your time with us to result in better mental health, less suffering, and more peace and happiness in your life.

Sincerely,

Caroline B. Williams, PhD, MP
Clinical Prescribing Psychologist

Valerie Fisher
Office Manager

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PATIENT REGISTRATION

PLEASE PRINT IN BLACK INK

(Other colors and pencil do not scan well)

Patient Full Name: ____ Date_____/_____/_____

Residence Address: _____________________________ City: _____________ State: _____ Zip: ________

Mailing Address*: ________________________________ City: _____________ State: _____ Zip: ________

*If different from residence address.

SS#______________________ Sex: _____ DOB: _____/_____/_____ Home Phone: (____) ________________

Cell Phone: (____) ______________ Email:____

Patient Employer: ___________________________________Work Phone: (____) ____________________

If Student: _____ H.S: ___________________________ College: ______________________________________

Referred By: ____

Person to contact in emergency: ______________________________ Phone: (____) _____________________

PERMISSIONS:

Where may we leave a message? Home: □yes □no Work: □yes □no Cell: □yes □no Email: □yes □no

INSURED/RESPONSIBLE PARTY INFORMATION:

Responsible Party:____

SS#:_____________________ DOB:___/____/____

Employer: ____ Phone: (____) ________________________

Insured's Primary Ins. Co: _________________________ I.D.#: _________________ Group #: ____________

Secondary Insurance Company: _____Yes _____No

Company: ____________________________ I.D.#__________________Group #:_________________

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all of my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.

Name: ____

Signature: ____ **Date:** _______________________

of person financially responsible

 Client Initials ____

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Patient Name: ______________________________ Date: ____________________

MENTAL HEALTH POLICIES AND PROCEDURES

Please Read Carefully!

Part I: ABOUT DR. WILLIAMS

1) Dr. Williams has received a New Mexico license for prescribing mental health medications. In addition to obtaining a PhD in clinical psychology, she has:
   *completed a post-doctoral master's degree in psychopharmacology.
   *completed a 100 patient, 400 hour practicum, under supervision.
   * passed a national credentialing exam about mental health medications.
   *completed a 24 month conditional prescribing period under supervision.

2) Dr. Williams may prescribe medications that are used for the treatment of mental health disorders. She cannot refill routine prescriptions for medical conditions, and cannot prescribe or monitor the use of opiates or suboxone.

3) New Mexico law requires that Dr. Williams coordinate her medication management of your mental health condition with your primary care physician. Thus, your consent for the exchange of information between Dr. Williams and your PCP is also required in order for her to provide this treatment. If you do not currently have a primary care physician (PCP), Dr. Williams will work with you to find medical services so that you can establish care.

My Primary Care Physician is: ____

City: ______________________________ Phone Number: ______________________

□ I do not have a primary care physician

Part II: PATIENT'S RIGHTS

1. You have the right to a confidential relationship with Dr. Williams. Within certain legal limits (see #4 and #5 below), information revealed by you during the course of treatment will be kept completely confidential and will not be revealed to any agency or other person without your written permission.
2. You have the right to receive a summary of your records, except in limited legal or emergency circumstances.
3. If you ask for it, any part of your records on file can be released to any agency or person you specify. At the time of your request, Dr. Williams may discuss with you whether or not releasing that information to that agency or person might be harmful to you in any way.
4. Under certain legally defined situations, Dr. Williams is required to reveal information to other agencies or persons. In such instances she is not required to notify you that such information has been released. These situations include:
   a. If you reveal information about child abuse, or neglect or elder adult abuse, she is required by law to report this to the appropriate authority.
   b. If you threaten death to another person, she is required by law to warn the intended victim and to notify law enforcement.

   c. If you threaten to seriously injure or kill yourself, she is required to notify the appropriate crisis intervention authorities.
   d. If you are in treatment by court order, the results of the treatment or tests ordered may be revealed to the court, depending on the circumstances of the court order.
   e. If you file a complaint or lawsuit against Dr. Williams, she may disclose relevant information regarding your treatment in order to defend herself.
   f. If you have not paid your bill within 60 days, Dr. Williams may release *relevant* financial information to a collection agency in order to obtain payment.
5. You have the right to ask questions about Dr. Williams, or about procedures used in the course of your treatment. If you ask, she will explain her customary approach and methods to you.
6. You have the right to choose NOT to receive treatment from Dr. Williams. If you choose this, she will provide you with names of other qualified professionals.
7. You have the right to terminate treatment any time without any financial, legal, or moral obligations Other than those you have already incurred.

Part III: INTERNET AND SOCIAL MEDIA POLICY

Dr. Williams has adopted the following social medical policy in order to safeguard privacy and confidentiality for her and her patients, and to maintain treatment boundaries.

1. Friending: Dr. Williams does not accept friend or contact requests from current or former patients on any social networking site (Facebook, Linked In, etc.).
2. Communication: The following methods of electronic communication are not secure and may not be checked regularly by Dr. Williams: SMS (mobile phone text messaging), messaging on social networking (Twitter, Facebook, Linked In, etc.), wall postings, or @replies. Please avoid using these and other means of engaging with Dr. Williams in public online. The office manager will return texts to the main office number but such texts are not confidential or secure.
3. Business Review Sites: You may find Dr. Williams on such sites as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums where users rate their providers and add reviews. If you should find Dr. Williams listed on any of these sites, please know that her listing does not represent a request for a testimonial, rating, or endorsement, and is most likely listed without her knowledge. You have a right to express yourself on such sites if you so choose. However, due to confidentiality, Dr. Williams cannot respond to any review on these sites, either positive or negative. In fact, in most cases, Dr. Williams may never see these reviews. If you have a complaint or concern about the treatment you are receiving, please consider sharing it in person with Dr. Williams, so that it can be addressed and resolved.
4. Email: The e-mail option on Dr. Williams' website is not encrypted or confidential. Please use it for administrative purposes only. Be aware that all emails are retained in the logs of internet providers of both the sender and the recipient. These logs are theoretically available for reading by the system administrator(s) of the internet service provider. Any emails that Dr. Williams receives from you and any responses she sends will become part of your legal medical record. Dr. Williams provides an option for encrypted electronic messaging through her portal for established patients (see #5 below).
5. Secure (encrypted) electronic communication: Established patients can securely message through the encrypted patient portal online, and will receive login information at their first appointment. Any encrypted messages that Dr. Williams receives from you and any responses she sends will become part of your legal medical record.

6. Electronic appointment reminders: You can request appointment reminders through text, email, or by phone call. Complete the form in this packet to request this.

Part IV: THE TREATMENT PROCESS

1. Participating in psychological/psychiatric treatment can result in a number of benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek treatment. Working towards these benefits, however, requires effort on your part and may result in your experiencing considerable discomfort. Remembering and resolving unpleasant events through mental health treatment can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals can also lead to discomfort and may result in changes that were not originally intended. Different medication trials may also result in unintended side effects or initial discomfort before you begin to feel better.
2. Dr. Williams provides a variety of treatment and diagnostic interventions. In addition to a general appointment, she may recommend formal psychological testing or genetic testing in order to improve treatment outcomes. These additional diagnostic interventions may generate additional costs and/or copayments, which will be explained to you ahead of time.

Part V: OFFICE POLICIES

1. Scheduling and Appointments:
    a. Schedule appointments with Dr. Williams in person, by phone (505-819-0859), through her web site at www.carolinewilliamsphd.com, or through the patient portal for established clients.
2. Missed appointments: include not appearing for a scheduled appointment, cancelling an appointment without 24 hours' notice or arriving at an appointment more than 10 minutes late. If you arrive more than 10 minutes past your appointment time, Dr. Williams may not be able to see you and you may be rescheduled for another time.
    a. Treatment may be discontinued if you miss an appointment three times without giving 24 hours' notice.
    b. Please arrive at least 5 minutes early for your appointment to allow enough time to check in.
    c. Face-to-face contact time during appointments scheduled for an hour usually lasts 50-55 minutes. Contact time for appointments scheduled for ½ hour usually lasts 20-25 minutes. Dr. Williams uses the remainder of the appointment time for completing tasks necessary for your treatment. This might include writing progress notes, communicating with the pharmacy about your prescription, communicating with your therapist and/or primary care doctor as needed, managing insurance and billing issues, and dealing with other management issues as they arise.
3. Children over the age of 24 months may not be present during an adult's session, and children under age 14 yrs may not remain in the waiting area unattended. Child care is not available at the office. Please make arrangements for supervision of your children during your appointment time. If you arrive for your appointment with children who need supervision, your appointment will be rescheduled.
4. Emergencies: If you have a clinical emergency, call 911, or Crisis Response of Santa Fe at 820-6333, or go to a hospital emergency room.
5. Non-Emergency Clinical Issues: For clinical issues between appointments, such as problematic side effects, contact Dr. Williams during business hours, 8 am-5 pm T-W-Th at 505-819-0859, or electronically through the patient portal.
6. Prescription Refill Policies: Please plan ahead when you need a medication refill so be sure to request a refill before your medication runs out.

   a. Remember that it may take up to 3 business days for Dr. Williams to generate a refill.
   b. You are expected to attend all follow up appointments as requested by Dr. Williams. Clients on 'maintenance' medication are expected to attend a check-up appointment every three months. Clients who do not attend their appointments as requested may be tapered off medication or referred out.
   c. If you have trouble obtaining your medication or medication refills, please contact the office directly rather than relying on the pharmacy to contact us.

7. Lab Work Policies: It is your responsibility, as the patient, to schedule and attend follow-up appointments with Dr. Williams following any laboratory or other tests ordered, in order to discuss the results of these tests. This ensures that abnormal test results are addressed in a timely manner.
8. Random Drug Screens: You may be asked to participate in random drug screens (urine analysis) during your treatment with Dr. Williams. You may choose to decline such requests. However, your decision to decline a drug screen may affect Dr. Williams' decisions about your treatment, and may result in a referral to another treatment provider.
9. One Provider: Your treatment will work best if you receive all of your mental health medications from one provider. This includes receiving medical cannabis for mental health reasons. If one of your other doctors prescribes you a mental health medication or cannabis, please discuss it with Dr. Williams. If you consistently obtain psychiatric medications or cannabis from multiple doctors over time, Dr. Williams may refer you to another provider.
10. Treatment Participation: Your treatment will also work best if you follow Dr. Williams' requests and directions. She works to include you in the decision-making process and in treatment planning. Frequent disagreements with Dr. Williams' treatment recommendations, or lack of participation in treatment over time suggests that you may not be a good fit with Dr. Williams. Alternative providers and referrals will be provided in this case.

Part VI: FINANCIAL POLICIES

1. Responsible Party & Payment**:** The patient/responsible party is responsible for all fees. If Dr. Williams is a provider for your insurance plan, any deductibles or co-payments are expected at the time of your appointment. You are responsible for any balance on your account not paid by your insurance. Non-emergency treatment may be discontinued in response to a refusal to pay for services.
2. Co-pays and Coinsurance: Information initially obtained from your insurance about co-pays, deductible and coinsurance is not always correct. Once the first claims are paid, we can be more specific with you about your portion of the bill. A $75 deposit may be requested at the 1st appointment if we are unable to obtain an estimate of your portion from your insurance.
3. Payment Options: Cash, check, credit and debit cards are accepted for payment. Payment is expected at the time of appointment. If you choose to pay in cash, please bring the correct amount as limited change is stored in the office.
4. Returned Checks: Returned checks are assessed a $25.00 fee.
5. Collection Policy**:** You agree to pay any outstanding bills within 10 days of receipt. If payment is not received within 60 days, your account may be turned over to a collection agency. In such an event, the patient/responsible party will be responsible for all reasonable costs of collections, including attorney's fees, if any. The minimum collection fee will be 40% of the total account balance.
6. Records Requests: Records are copied at $1.00 per page for the first 10 pages, then $.20 per page, plus gross receipts tax, and billed directly to you. Federal Law allows 30 days for processing records requests.

 Client Initials ____

7. Letters: are often requested by patients (or their parents) for doctors, schools, employers, etc. Such letters may be provided with an administrative fee for this service, minimum $25.00+gross receipt tax. Additional fees depend on the time involved with the specific request.
8. Gross Receipts Tax: applies to all charges except for deductibles, coinsurance and copays from managed care plans.

CONCLUSION:

Please feel free to discuss any questions or concerns with Dr. Williams before signing this form. You may obtain a copy of this form for reference and documentation.

I agree to participate in treatment under these conditions with Caroline B Williams, PhD MP.

______________________________ ____________________

Signature of Patient Date

MEDICARE OPT OUT (Complete if you have Medicare)

Dr. Caroline Williams has “opted-out” of the Medicare program, which means that she is not a Medicare provider, and does not bill Medicare for her services. As a result,

1) Medicare billing limits do not apply to Dr. Williams’ charges.
2) Medicare may not reimburse for Dr. Williams’ services.
3) Medigap and other supplemental insurance plans may choose not to reimburse or make payments for Dr. Williams’ services.

You, as a Medicare recipient, have the option to obtain services from another provider who does accept Medicare. By signing below, you agree not to file a claim with Medicare for Dr. Williams’ services, and acknowledge receipt and understanding of the above information.

____ _______________

Signature of Insured Date

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MEDICAL & SOCIAL HISTORY

Patient Name: ______________________________ Date of Birth ____________________

Date Completed: _________________ Age: ________ Height: ________ Weight: ________

What pharmacy do you prefer? (please include street name) ____________________________

Drug, medication or medical equipment allergies (latex, etc.): __________________________
____

List all medications, supplements, and herbals (including medical cannabis) that you take occasionally, as needed, or daily: **(including medical cannabis)**

Medication/supplement	***Dose*** *(example,10 mgs)*	***Tablet or Capsule***	***Usage*** *(example 2 times/ day)*	***Prescribed by***

Please complete the following questions regarding your current and/or past medical history. Place a check mark or 'x' next to the medical conditions that you have had or have, indicating whether they occurred in the past or are happening presently. If you have never had trouble with a particular medical condition, leave that row blank.

Now	Past	**Gastrointestinal**	Now	Past	**Genital & Urinary Systems**
		Irritable Bowel Syndrome			Kidney Stones
		Inflammatory Bowel Disease			Gout
		Crohn's			Interstitial
		Ulcerative Colitis			Cystitis
		Gastritis or Peptic Ulcer Disease			Frequent Urinary Tract Infections
		GERD (reflux)			Frequent Yeast Infections
		Celiac Disease			Erectile Dysfunction
		Other:			Other:
		Cardiovascular			**Musculoskeletal Pain**
		Heart Attack (date:)			Osteoarthritis
		Other Heart Disease			Fibromyalgia
		Stroke (date:)			Chronic Pain
		Elevated Cholesterol			Other:
		Arrythmia (irregular heart rate)			**Inflammatory/Autoimmune**
		Hypertension (high blood pressure)			Chronic Fatigue Syndrome
		Rheumatic Fever			Autoimmune Disease

		Mitral Valve Prolapse			Rheumatoid Arthritis
		Other:			Lupus
		METABOLIC/ENDOCRINE			Immune Deficiency Disease
		Type 1 Diabetes			Herpes-Genital
		Type 2 Diabetes			Severe Infectious Disease
Now	**Past**		**Now**	**Past**	
		Hypoglycemia			Poor Immune Function (frequent infections)
		Metabolic Syndrome (insulin resistance)			Food Allergies
		Hypothyroidism (low thyroid)			Environmental Allergies
		Hyperthyroidism (overactive thyroid)			Multiple Chemical Sensitivities
		Endocrine Problems			Latex Allergy
		Polycystic Ovarian Syndrome (PCOS)			Other:
		Infertility			**RESPIRATORY DISEASES**
		Weight Gain			Asthma
		Weight Loss			Chronic Sinusitis
		Frequent Weight Fluctuations			Bronchitis
		Bulimia			Emphysema/COPD
		Anorexia			Pneumonia
		Binge Eating Disorder			Tuberculosis
		Night Eating Disorder			Sleep Apnea
		Eating Disorder (non-specific)			Other:
		Other:			**SKIN DISEASES**
		CANCER			Eczema
		Lung Cancer			Psoriasis
		Breast Cancer			Acne
		Colon Cancer			Melanoma
		Ovarian Cancer			Skin Cancer
		Prostate Cancer			Other:
		Other:			**NEUROLOGICAL DISEASES**
		PSYCHIATRIC DISEASES			Mild Cognitive Impairment
		Depression			Autism
		Anxiety			Memory Problems
		Bipolar Disorder			Parkinson's Disease
		Schizophrenia			Multiple Sclerosis
		Dissociative Disorder			ALS
		Post-Traumatic Stress Disorder			Headaches
		Obsessive-Compulsive Disorder			Seizures
		Gambling Addiction			Migraines
					ADD/ADHD
					Learning Disability

Other medical conditions not listed above: ____
____

Auto accidents: ____

Tobacco Use: ____
(Non-smoker, Ex-smoker, Light smoker, Moderate smoker, Heavy smoker, Chews tobacco, etc…)

Psychiatric Medications: Please mark any medications that you have tried in the past.

Generic Drug Name	Brand Name	Past Use	Worked	Bad Reaction (explain)
Antidepressants				
Imipramine	Tofranil			
Desipramine	Norpramin			
Amitriptyline	Elavil			
Nortriptyline	Pamelor			
Trazodone	Desyrel, Oleptro			
Nefazodone	Serzone			
Fluoxetine	Prozac			
Bupropion	Wellbutrin			
Sertraline	Zoloft			
Paroxetine	Paxil			
Venlafaxine	Effexor			
Esketamine	Ketanest, Spravato			
Desvenlafaxine	Pristiq			
Fluvoxamine	Luvox			
Mirtazapine	Remeron			
Citalopram	Celexa			
Escitalopram	Lexapro			
Duloxetine	Cymbalta			
Vilazodone	Viibryd			
Atomoxetine	Strattera			
Vortioxetine	Trintellix			
Levomilnacipram	Fetzima			
Milnacipram	Savella			
Phenelzine	Nardil			
Tranylcypromine	Parnate			
Selegiline	Emsam (patch)			
Mood Stabilizers				
Lithium	Eskalith			
Olanzapine/Fluoxetine	Symbyax			
Carbamazapine	Tegretol			
Divalproex	Depakote			
Lamotrigine	Lamictal			
Oxcarbazapine	Trileptal			
Gabapentin	Neurontin			
Pregabalin	Lyrica			
Stimulants				
Methylphenidate	Ritalin, Concerta			
Dexmethylphenidate	Focalin			
Dextromethylphenidate	Dexedrine			
Lisdexamphetamine	Vyvanse			

Generic Drug Name	Brand Name	Past Use	Worked	Bad Reaction (explain)
D-and L-amphetamine	Adderall			
Modafinil	Provigil, Sparlon			
Armodafonil	Nuvigil			
Antipsychotics				
Chlorpromazine	Thorazine			
Clozapine	Clozaril			
Quetiapine	Seroquel			
Perphenazine	Trilafon			
Loxapine	Loxitane			
Fluphenazine	Prolixin			
Haloperidol	Haldol			
Pimozide	Orap			
Risperidone	Risperdal			
Paliperidone	Invega			
Olanzapine	Zyprexa			
Ziprasidone	Geodon			
Iloperidone	Fanapt			
Asenapine	Saphris			
Lurasidone	Latuda			
Ariprprazole	Abilify			
Brexpiprazole	Rexulti			
Cariprazine	Vraylar			
Anti-Anxiety Medications				
Diazepam	Valium			
Chlordiazepoxide	Librium			
Clonazepam	Klonopin			
Lorazepman	Ativan			
Alprazolam	Xanax			
Buspirone	BuSpar			
Gabapentin	Neurontin			
Hydroxyzine	Atarax, Vistaril			
Propranolol	Inderal			
Atenolol	Tenormin			
Guafacine	Tenex, Intuniv			
Clonidine	Catapres, Kapvay			
Pregabalin	Lyrica			
Prazosin	Minipress			
Experimental Therapies				
Medical Cannabis				
Ketamine	Ketalar			
PsiLocybin (Under Medical Supervision)				

Generic Drug Name	Brand Name	Past Use	Worked	Bad Reaction (explain
MDMA (Under Medical Supervision)				
Other:				
Other:				
Herbal, Supplements, Medical Foods				
L-Methylfolate	Deplin			
St. John's Wort				
SAM-E				
Omega-3 EPA				
5-HTP				
Electricity-Based Therapies				
Electroconvulsive Therapy (ECT)				
Transcranial Magnetic Stimulation (TMS)				
Other:				

Hospitalizations and Surgeries:

Where	When	Reason

<u>Family History</u>: Do any of your relatives have the following: (mark the box to the left of each illness)

	Alzheimer's		High Blood Pressure
	Diabetes		Senile Dementia
	Tuberculosis		Asthma
	Heart Disease		Kidney Disease
	Parkinson's		Stroke
	Autoimmune Disorder		Other:___________________
	Cancer (type:)		Mental Illness

<u>Gynecological History (Women Only)</u>

If female, might you be pregnant? ____
Birth Control Method: ____
Provide number of:
Pregnancies ______ Caesarean _____ Vaginal Deliveries _____ Miscarriage _____ Abortion______

Now	Past	Women's Disorders/Hormonal Imbalances
		Fibrocycstic Breasts
		Endometriosis
		Fibroids
		Infertility
		Painful Periods
		Heavy Periods
		PMS
		Decreased libido
		Trouble reaching orgasm

Are you in menopause? □ yes □ no Age at Menopause: _______

Men's History (Men only)

Have you had your testosterone checked? □ yes □ no
Testosterone results □ normal □ low □ high

Now	Past	Men's Disorders
		Change in Libido
		Impotence
		Difficulty Obtaining an Erection
		Difficulty Maintaining an Erection

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What did you eat for the last 2 days?

Day 1	Day 2
Breakfast ______________________ ______________________ ______________________ ______________________ ______________________	Breakfast ______________________ ______________________ ______________________ ______________________ ______________________
Lunch ______________________ ______________________ ______________________ ______________________ ______________________	Lunch ______________________ ______________________ ______________________ ______________________ ______________________
Dinner ______________________ ______________________ ______________________ ______________________ ______________________	Dinner ______________________ ______________________ ______________________ ______________________ ______________________
Snacks ______________________ ______________________ ______________________ ______________________ ______________________	Snacks ______________________ ______________________ ______________________ ______________________ ______________________
Drinks ______________________ ______________________ ______________________ ______________________	Drinks ______________________ ______________________ ______________________ ______________________

"Let food be thy medicine, and medicine be thy food" - Hippocrates

"He that takes medicine and neglects diet wastes the skills of the physician". - Chinese Proverb

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AUTHORIZATION TO RELEASE INFORMATION TO PRIMARY CARE PROVIDER

CLIENT NAME: ______________________ **DATE OF BIRTH:** ______________________

I do hereby authorize Dr. Caroline Williams to: [x] **Disclose to** [x] **Exchange with** [x] **Obtain from**

My Primary Care Provider ____

Address: ______________________ Phone: ______________________ Fax: ______________________

Indicate the type of information to be disclosed by indicating Yes or No for EACH choice below:

[Yes] No	**Mental Health Treatment**	[Yes] No	**Alcohol/Drug Abuse Treatment**	[Yes] No	Progress Notes
[Yes] No	Intake Narrative/ASI	[Yes] No	Program Attendance/Compliance	[Yes] No	Testing & Lab Results
[Yes] No	**Drug Screen Results**	[Yes] No	Treatment Plan	[Yes] No	**HIV Status**
[Yes] No	Medical Information	[Yes] No	Progress in treatment/Prognosis	[Yes] No	Emergency Medical information

[Yes] No Other specific information to be released Please specify: ______________________

[Yes] No All records (please circle if Yes)

This information to be released by means of: [x] Photocopies/mail [x] Verbal/telephone [x] Fax

Information to be released is for services during the period of ______________ to <u>completion of treatment with Dr. Williams</u>

The purpose of this disclosure is: [x] Continuity of care □ Other (Please specify) ______________________

I understand that my records are protected by state and federal confidentiality laws and cannot be disclosed without my written consent unless otherwise permitted by law. I understand that I may revoke this authorization at any time except to the extent that action has already been taken. I have the right to revoke this consent, but revocation will not be effective until received in writing by the person in possession of my records. If you give written consent to re-disclose your information by the recipient, it may no longer be protected by federal or state laws. If not revoked earlier, this consent will expire as specified below, or if not specified, within one year from the date signed.

Date consent expires: <u>upon completion of treatment with Dr. Williams</u> or one year from the date of client or legal guardian's signature.

______________________ ______________ ______________________ ______________
Signature of client or legal guardian Date Signature of Witness Date

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In the case of Substance Abuse Records: This information has been disclosed to you from records protected by Federal Confidentiality Rule 42 CFR, Part 2. The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal Rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse client.

NOTICE OF PRIVACY PRACTICES
Effective Date: April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
PLEASE READ IT CAREFULLY.

Uses and Disclosures:
Treatment: Mental health providers do not disclose information to other health care professionals without your written consent.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, services provided, and the medical condition being treated. Should your account become delinquent, your information may be used to seek payment through a collection agency.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of this mental health practice. For example, information on the services you receive may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your mental health information may be disclosed to law enforcement when a legitimate subpoena or court order is presented. Further, information regarding physical, sexual or emotional abuse of a child or an elderly person, and potentially imminent suicidal and/or homicidal behavior, may be released to law enforcement without your knowledge.

Public Health Reporting: Mental health professionals do not participate in public health reporting.

Licensing Boards: Revelation that another mental health provider has engaged in a sexual relationship with a client must be reported to the licensing board for that provider. The client involved may remain anonymous in such a report.

Additional Uses of Information: Mental health professionals in this office do not mail Appointment reminders. Your health information will not be used to provide you with information about treatments through the mail, and will not be used for fund raising activities.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Individual Rights: You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your protected health information
2. The right to receive confidential communications concerning your medical condition and treatment
3. The right to inspect and copy your protected health information
4. The right to amend or submit corrections to your protected health information.
5. The right to receive an accounting of how and to whom your protected health information has been disclosed
6. The right to receive a printed copy of this notice

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Request to Inspect Protected Health information: As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the office manager or your mental health provider.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Dr. Caroline B. Williams
2204 Brothers Rd, Ste. B
Santa Fe, NM 87505

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person: The name and address of the person you can contact for further information concerning our privacy practice is:

Dr. Caroline B. Williams
2204 Brothers Rd, Ste. B
Santa Fe, NM 87505

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Your Protected Health Information:

Your protected health information will be used by your treatment provider or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices:

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information:

You may request a restriction on the use or disclosure of your protected health information. Your provider may or may not agree to restrict the use or disclosure of your protected health information. If your provider agrees to your request, the restriction will be binding on the practice. Use and disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent:

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation is received will not be affected.

Reservation of Right to Change Privacy Practices:

Your provider reserves the right to modify the privacy practice outlined in this notice.

I have received a copy of the privacy guidelines for private health information as they are applied to Dr. Williams' practice. I have reviewed this consent form and give my permission to Dr. Williams to use and disclose my health information in accordance with the guidelines in this form and the office's general privacy policies.

______________________________ ______________________

Printed Name **Date of Birth**

______________________________ ______________________

Signature **Date of Signature**

CONSENT TO RECEIVE TEXT AND VOICE TELEPHONE CALL REMINDERS

In addition to providing courtesy appointment reminder e-mails to our patients, we are also able to provide appointment reminder phone calls and/or text messages. In order to authorize receiving calls and/or text messages, please fill out the information below and provide the phone number where you wish to receive these messages.

By providing your cell phone number below, you consent to receiving appointment reminder calls and/or text messages on your cell phone. If you would like us to utilize a different phone number, please provide that number below instead of your cell phone number.

I understand that once Dr. Caroline Williams sends a text or voice message, she no longer has control over who has access to this information.

Upon reviewing the above information, I still request that Dr. Williams send appointment reminders via text and/or voice messaging.

Patient Name: ____________________________ Date of Birth: ________________

____________________________ ____________________
Signature Date

Preferred contact mode is:

☐ Cellular Phone Call
☐ Cellular Text Message
☐ E-mail
☐ All of the above

Cellular phone number to call and/or text: __________________________

E-mail Address: __________________________________