NAPG

NORTHWEST·ARKANSAS·PSYCHOLOGICAL·GROUP

DRUG AND ALCOHOL PROGRAM

FEE AGREEMENT:

I understand that I am responsible for payment of all fees before records/certificates will be released.

I understand that there will be a $50 cancellation fee for any sessions not attended or not cancelled with at least 24 hours notice.

_____ _____

Name of patient Date

NAPG

NORTHWEST·ARKANSAS·PSYCHOLOGICAL·GROUP

NEW PATIENT INFORMATION FORM

Date: _____

Patient's Name: _____ Age: _____ Sex: _____

Social Security Number: _____ Date of Birth: _____

Driver's License Number and State: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: (Name) _____

Relationship: _____ Phone Number: _____

How did you hear about us? Who referred you? _____

HIPAA packet offered to patient: (Sign) _____ (Date) _____

DWI / MIP / FAKE ID INFORMATION

Do you have a lawyer? Yes/No If yes, who is your lawyer? _____

Arrest Date(s): _____

Have you had your initial court hearing? Yes/No Have you been sentenced? Yes/No

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NORTHWEST·ARKANSAS·PSYCHOLOGICAL·GROUP

Patient Income Screening/Services Eligibility Form
Northwest Arkansas Psychological Group Drug and Alcohol Treatment Program

Date of Screening: _____

INDIVIDUAL CLIENT NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

ANNUAL INCOME: _____

SALARY/WAGES: _____

RETIREMENT/PENSION: _____yes _____no

PUBLIC ASSISTANCE: _____yes _____no

OTHER SOURCES OF INCOME: _____

AMOUNT: _____

NUMBER OF DEPENDENTS: _____

Circle One: Married Single Divorced

HOW DO YOU EXPECT TREATMENT TO BE FUNDED? _____

By my signature, I attest that the above financial information is accurate:

_____
Client Signature

I attest that I witnessed the client's appropriate documentation of the above financial information, and/or their verbal estimate of the above income:

_____
Staff Signature

N·A·P·G

NORTHWEST·ARKANSAS·PSYCHOLOGICAL·GROUP

ADMISSION TO OUTPATIENT COUNSELING SERVICES

I, _____, hereby authorize Northwest Arkansas Psychological Group to perform such services as necessary for evaluation and treatment of the condition for which I am presenting myself. I have been given the client handbook and do acknowledge that I have read and understand the contents of this handbook.

_____

Patient Date

_____

Clinician Date

N·A·P·G

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Name:
Date:

DRUG USAGE QUESTIONS

1. Can you plan how much you are going to use or drink and stick to it?
2. Have you tried to cut down?
3. Do all of your activities revolve around using, buying, and getting over it?
4. Do you get drunk or high at work or school?
5. Do you miss work or school because you are using or crashing?
6. Have you given up sports or other activities since you have been using or drinking?
7. Has your use caused legal, school, or family problems?
8. Do you have to use or drink more to get high now than when you started?
9. Have you ever had withdrawal problems when you stopped using?
10. Do you ever use or drink to stop feeling bad rather than to get high?
11. Have you ever had blackouts?
12. Have you lost your sober friends?
13. Have you ever been treated for chemical dependency?

VII. SEXUAL HISTORY

a. Sexual contact with anyone who has ever used I.M/I.V. injection for Drug Use:

b. Are you a member of a sexual minority:

c. Have you ever had STD/TB Education: d. If STD/TB ED, Where or Who:

e. Comments:

PSYCHOSOCIAL AND SUBSTANCE USE HISTORY

Client's name: _____ Date: _____
Social Security Number: _____ Race: _____
Age: _____ Birthdate: _____ Sex: _____
Address: _____
Telephone Number: _____
In your own words, why did you come here? _____
_____
_____

A. Marital History ("spouse" refers to husband, wife, girlfriend, or boyfriend.)

1. Marital status (circle the word that best explains your status):

Single	Engaged	Married	Separated
Divorced	Widowed	Divorced/Remarried	Common-Law

2. If you have been married, how many times? _____
3. How old were you when you first married? _____

B. Educational History (please circle)

1. Grade School
2. High School: 1yr 2yrs 3yrs 4yrs GED
3. College: 1yr 2yrs 3yrs 4yrs Postgraduate: MA MD PhD
   Other: _____
4. Have you ever been in special education classes? Yes / No
5. If so, why were you in these classes? _____

C. Drinking and drug history relative to school

1. Are you still in school? Yes / No If yes, name of school: _____
2. Has your drinking or drug use ever caused problems in school? _____
3. Have you ever been sent home from school because of drinking or drug use? Yes / No
4. Have you ever been suspended from school? Yes / No
5. Have you ever been expelled from school? Yes / No
   If yes, why were you expelled? _____
6. Are you having any other school problems? Yes / No
   If yes, please explain: _____
7. Do you have enough credits to graduate? Yes / No
   If no, please explain: _____

D. Military History

1. Have you ever been in the armed forces? Yes / No If yes, please complete #2-5
2. What was (is) your rating and rank? _____
3. How long were you in the service? _____
4. Date enlisted: _____ Date entered: _____
5. Current military status: _____ Type of discharge (if applicable): _____

E. Employment History

1. Are you currently employed? Yes / No How long at this job? _____
2. Name of employer: _____
3. Type of work: _____ Gross annual income: _____
4. How long have you done this type of work? _____
5. What type of work would you like to do, even though you may not have the necessary training or skills? _____
6. Employment history (list most recent jobs first):

	Job Title	Date Started	Date Left	Reason for Leaving
a.				
b.				
c.				

7. Describe any problems on the job (past or present): _____

F. Family and Friends History

1. Are your parents still living together? Yes / No
2. Describe your father: _____
3. Describe your mother: _____
4. List your brothers and sisters, and circle any stepbrothers or stepsisters:
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____
   f. _____
   g. _____
   h. _____
5. Were you in order of birth (#1 oldest, #2 middle, or #3 youngest, etc.): _____
6. Which brother or sister are you closest to? _____
7. Which brother or sister are you the least close to? _____
   Explain: _____
8. Which person in your family makes the decisions? _____
9. If you needed to borrow money, which member of your family would you ask? _____
   Why? _____
10. Do you have a girlfriend/boyfriend? Yes / No
11. Do the two of you spend a lot of time together? Yes / No
12. Would you say that your girlfriend/boyfriend has a drinking problem? _____
13. Would you say that your girlfriend/boyfriend has a drug problem? _____

14. Does anyone in your family suffer from the following (circle):

Nervous breakdown	Fits or convulsions	Nervousness	Migraine headaches
Visions	Stuttering	Alcohol problem	Drug abuse

Times when they could not remember what they were doing
Times when they acted strangely or peculiarly

If you have circled any of the choices above, state which family member and when and how you were affected by it: _____

15. What do you do outside of work or school in your free time? (Include things such as hobbies and leisure activities): _____

16. About how many close friends do you have? _____
17. Describe them by first name, sex, and age: _____

18. Have any of them ever had a drinking or drug problem? (If yes, please describe) _____

19. List your children (oldest to youngest), and circle those who are adopted or are stepchildren:
    a. _____
    b. _____
    c. _____
    d. _____
    e. _____

G. Medical History

1. Do you or anyone in your family have chronic medical problems? _____

2. Are you allergic to anything? _____
3. Are you presently under the care of a doctor? If yes, why? _____

4. Date of last physical: _____
5. List any medical hospitalizations: _____

6. Are you presently taking medications? (If yes, note who prescribed them, dosage and strength, how long you have been taking them, date of last dose, and any side effects)

7. Have you had any recent change in your weight, eating habits, or sleep patterns? (If yes, describe) _____

_____

_____

H. Legal History

1. Do you have any arrest charges pending? Yes / No
   If yes, please list below:

Charge	Court Date	Location
a.		
b.		
c.		

2. Have you had previous arrests? Yes / No
   If yes, what were the charges and when were they filed?
   a. _____
   b. _____
   c. _____
3. Are you on probation? Yes / No
4. Are you on parole? Yes / No
5. Are you under court supervision? Yes / No
6. Have you attended or are you attending a class on alcohol or drug safety? (Not including NAPG's Treatment Program?) Yes / No
   If yes, where? _____
7. Were you ordered to treatment by the Circuit Court? Yes / No
   If yes, which county and judge? _____
8. Do you have a lawyer or public defender? Yes / No If yes, who? _____
9. Were you referred to treatment by your lawyer? Yes / No
   If yes, what is your lawyer's name and phone number? _____

   _____
10. Would you consent to sign a release of information allowing us to communicate with any of the above agencies or authorities on specific treatment issues? Yes / No
11. What is your court date? _____
12. If not listed above, who referred you? _____

I. Alcohol, Drug Use, & Treatment History

1. Have you ever been treated for an alcohol problem before? Yes / No
   If yes, please circle the following applicable programs:
   Detoxification Rehabilitation Outpatient Therapy N/A
   Other: _____
   List treatment locations, dates, and indicate type (detoxification, rehabilitation, etc.): _____

   _____

   _____
   Did you finish treatment? Yes / No If no, explain: _____

   _____

   _____

2. Would you consent to sign a release of confidential information allowing us to communicate with any of these programs regarding specific treatment issues? Yes / No
3. Have you ever been involved with Alcoholics Anonymous or Narcotics Anonymous? Yes / No N/A If yes, how often did you/do you attend meetings? _____
Were the meetings: Open / Closed Do you have a sponsor? Yes / No
4. At what age did you first drink? _____
Please describe the circumstances and consequences: _____
_____
_____
5. At what age did you first lose control of your drinking? _____ Or I have never lost control of my drinking: _____
6. Have you ever had a blackout? Yes / No If yes, at what age? _____
Did your blackouts ever begin to increase? Yes / No N/A
7. When and why did you first become concerned about your drinking? _____
_____
_____
8. What is the average amount of hard liquor you consume? (Amount and frequency) _____
_____
_____
9. What is the average amount of beer you consume? (Amount and frequency) _____
_____
_____
10. What is the average amount of wine you consume? (Amount and frequency) _____
_____
_____
11. Do you ever go on "binges" or periods of uncontrolled drinking? Yes / No
Once a year Every 6 to 8 months Every 3 to 6 months
Every 1 to 3 months Every weekend N/A
Other: _____
12. Do you drink daily? Yes / No Amount: _____
13. How long have you been drinking daily (if applicable):
Just this last month 1 to 3 months 3 to 6 months 6 to 9 months
1 year 2 years Longer than 2 years
Other: _____
14. Have you ever had the "shakes" when you stop drinking? Yes / No
If yes, please describe: _____
_____
_____
15. Have you ever seen or heard things that were not actually there? Yes / No
16. Have you ever had delirium tremens (DTs)? Yes / No
If yes, please describe: _____
_____
_____
17. Has a physician ever told you to stop drinking? Yes / No
If yes, why? _____
_____

18. With whom do you usually drink? (Circle all that apply)

Spouse Other relative Neighbors By myself
Strangers Coworkers Friends at a bar Classmates

19. When drinking, how do you act and feel? (Circle all that apply)

Angry Mean and pick fights Get into arguments Happy
Have fun Get into physical fights Rarely get angry or violent
Other: _____

20. How do your parents, wife/girlfriend, or husband/boyfriend feel about your drinking?

Don't seem to mind Don't say much about it Nag me about it
Have threatened to leave me because of it N/A
Other: _____

21. Have your family activities changed because of your drinking? Yes / No
22. Has your sexual life changed because of your drinking? Yes / No
23. Have you ever quit drinking? Yes / No If yes, when? _____
How long did you stay sober? _____
Did this "dry" period follow any form of treatment? Yes / No
If yes, what type and where? _____
What things did you do to stay sober instead of drinking? _____
_____
_____
Did you have any symptoms when you stopped drinking? _____
_____
_____

24. Have you ever used cough syrup or other medication containing alcohol as substitutes for liquor or for the purpose of getting high? Yes / No
If yes, prescription or nonprescription? _____
Have you used any other alcohol substitutes? Yes / No
If yes, what? _____

25. What mood altering drugs have you taken? (Circle all that apply)

Tranquilizers (Valium, Librium, Miltown, etc.) Type: _____
Date started: _____ Date of last use: _____ Dosage: _____
Psychotropics (Stelazine, Cogentin, Thorazine, etc.) Type: _____
Date started: _____ Date of last use: _____ Dosage: _____
Barbiturates (Quaaludes, Phenobarbital, etc.) Type: _____
Date started: _____ Date of last use: _____ Dosage: _____
Amphetamines (Dexedrine, Phentermine, Ritalin, etc.) Type: _____
Date started: _____ Date of last use: _____ Dosage: _____
Sleeping pills (Ambien, etc.) Type: _____
Date started: _____ Date of last use: _____ Dosage: _____
Opiates (Heroin, Morphine, Opium, etc.) Type: _____
Date started: _____ Date of last use: _____ Dosage: _____
Pain Pills (Hydrocodone, Codeine, Oxycontin, etc.) Type: _____
Date started: _____ Date of last use: _____ Dosage: _____
Hallucinogens (LSD, PCP, etc.) Type: _____
Date started: _____ Date of last use: _____ Dosage: _____
Cocaine (In any form) Type: _____

Date started: _____ Date of last use: _____ Dosage: _____
Marijuana
Date started: _____ Date of last use: _____ Dosage: _____
Huffing (glue, paint thinner, etc.) Type: _____
Date started: _____ Date of last use: _____ Dosage: _____
Injection use (Heroin, Steroids, etc.) Type: _____
Date started: _____ Date of last use: _____ Dosage: _____
Other Type: _____
Date started: _____ Date of last use: _____ Dosage: _____

26. Have you ever received treatment for a drug problem? Yes / No
If yes, what type, when, and where? _____
_____
_____

27. When do you usually drink or use drugs? (Circle all that apply)

Weekends	After work/evenings	Occasionally during the day
Regularly during the day	Frequent, short "benders"	Long, occasional "benders"
Regularly and frequently		

28. Which of the following apply to you? (Circle)
I'm losing control of my drinking/drug use
I'm an alcoholic/drug addict
I can't stop myself
I am deteriorating rapidly
I know why I drink or use drugs
I hate myself
I have a drinking problem
My tolerance is decreasing
My tolerance is increasing
I need a drink when I wake up
I'm not eating regularly
I'm strictly a "social drinker"
I can quit anytime
I might be an alcoholic or drug addict
I have accidents or fall when drinking and sometimes injure myself
I'm a problem drinker or drug user, but not an addict
I get arrested because of my drinking or drug use
I have been unable to complete a task (or begin) because I was drinking
I have a drug problem

29. Which of these apply to you at this time? (Circle)

School problems	Physical problems	Financial problems
Family problems	Marital problems	Threat to job
Loss of job	Legal problems	Loneliness

30. What do you expect from treatment? _____
_____
_____
What can we expect from you? _____

31. In your own words, what is alcoholism or drug dependence? _____

32. Have you ever been treated for emotional or psychiatric problems? (Anxiety, depression, etc.) Yes / No
If yes, please state how many times, where, when, and if it was inpatient or outpatient: _____

33. Have you ever attempted or considered attempting suicide? Yes / No
If yes, please describe how many times, when, and any other information: _____

34. Please describe yourself and specifically list your strengths and weaknesses: _____

35. Are you interested in any further treatment or help in any area? Yes / No
If yes, please state which area you would like help with: _____

36. Please add any information you feel could be important to your treatment and a successful outcome: _____

37. Please list any questions: _____

38. Next of kin (name, relationship, and contact information): _____

Client's Signature: _____ Date: _____

Staff Signature: _____ Date: _____

For office use only:

Summary of Client's problems: _____

Code: _____

ASI Self-Report Form

This survey asks questions about your background and employment, your health and family relationships, your legal situation, and your alcohol and drug use. Please answer each question as accurately as you can by placing an "X" in the box next to the answer you select, writing in the appropriate number, or writing in information in the space provided.

PART I: YOUR BACKGROUND AND EMPLOYMENT

1. When were you born? _____
   Month Day Year

2. What is your current marital status? (Check one)

   ☐ **Never married** ☐ **Separated** ☐ **Divorced** ☐ **Married** ☐ **Widowed**

2a. Are you satisfied with your marital situation? ☐ **NO** ☐ **YES** ☐ **Indifferent**

3. How many days were you paid for working **in the past 30 days**?
   (Include paid sick and vacation days and days of "under the table" work) _____
   number of days

4. How much money did you receive from employment **in the past 30 days?**
   (Include paid sick and vacation days and days of "under the table" work) $ _____

5. Do you have a valid driver's license (not suspended or revoked)? ☐ **NO** ☐ **YES**

6. Do you have an automobile available on a regular basis? ☐ **NO** ☐ **YES**

Note: This is a self-report version of the Addiction Severity Index (ASI) used by the Center for Health Care Evaluation, VA Palo Alto Health Care System (152-MPD), Menlo Park, CA, 94025. See Rosen, Henson, et al. (2000: Addiction, 95, 419-425) for information on this version and see McLellan, Kushner, et al., (1992: Journal of Substance Abuse Treatment, 9, 199-213) for general information on the ASI.

PART II: YOUR HEALTH

7. How many days have you experienced medical problems **in the past 30 days?**

_____
number of days *(Do not include ailments directly caused by drugs/alcohol, except for serious ailments related to drugs/alcohol that would continue even if you were abstinent – for example, cirrhosis of the liver, abscesses from needles, etc.)*

8. How troubled or bothered have you been by these medical problems **in the past 30 days?**

☐ **Not at all** ☐ **Slightly** ☐ **oderately** ☐ **Considerably** ☐ **xtremely**

9. How important to you now is treatment for these medical problems?

☐ **Not at all** ☐ **Slightly** ☐ **oderately** ☐ **onsiderably** ☐ **xtremely**

10. **In the past 30 days,** have you had a significant period of time in which you have:

	NO	YES	Only when high, or in withdrawal from alcohol/drugs
a. Experienced **serious** depression, hopelessness, loss of interest, difficulty with daily functioning?	☐	☐	☐
b. Experienced **serious** anxiety/tension, uptight, unreasonably worried, inability to feel relaxed?	☐	☐	☐
c. Experienced hallucinations – saw things or heard voices that were not there?	☐	☐	☐
d. Experienced trouble understanding, concentrating, or remembering?	☐	☐	☐

11. **In the past 30 days, did you have a significant period** (it may have been a direct result of alcohol/drug use) in which you have:

	NO	YES
a. Experienced trouble controlling violent behavior, including episodes of rage, or violence?	☐	☐
b. Experienced serious thoughts of suicide (seriously considered a plan for taking your life)?	☐	☐
c. Attempted suicide?	☐	☐

12. **In the past 30 days,** how many days have you experienced these psychological or emotional problems? _____
number of days

13. How much have you been troubled or bothered by these psychological or emotional problems **in the past 30 days?**

☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

14. How important to you now is treatment for these psychological or emotional problems?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

15. **In the past 30 days,** have you been prescribed medication for any psychological or emotional problems?..... ☐ NO ☐ YES

PART III: YOUR FAMILY RELATIONSHIPS

16. In the past 30 days, have you had significant periods in which you have experienced **serious problems getting along with:**

	NO	YES	No recent contact
a. Your mother?.....	☐	☐	☐
b. Your father?	☐	☐	☐
c. Your brothers/sisters?	☐	☐	☐
e. Sexual partner/spouse	☐	☐	☐
f. Children?	☐	☐	☐
g. Other signficant family (SPECIFY: _____)	☐	☐	☐
h. Close friends	☐	☐	☐
i. Neighbors.....	☐	☐	☐
j. Coworkers.....	☐	☐	☐

17. **In the past 30 days,** how many days have you had **serious** conflicts with your family? ..... _____ number of days

18. How troubled or bothered have you been by family problems **in the past 30 days?**

☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

19. How important to you now is treatment or counseling for these family problems?

☐ ☐ ☐ ☐ ☐

Not at all Slightly Moderately Considerably Extremely

PART IV: YOUR ALCOHOL AND DRUG USE

20. How many days did you drink alcohol **in the past 30 days?** ..... _____ number of days

21. How many days did you drink alcohol to intoxication **in the past 30 days?** _____ number of days

22. How much money would you say you spent on alcohol **in the past 30 days?** $ _____

23. **In the past 30 days,** how many days have you experienced alcohol problems? _____ number of days

24. How troubled or bothered have you been by these alcohol problems **in the past 30 days?**

☐ Not at all ☐ Slightly ☐ oderately ☐ onsiderably ☐ xtremely

25. How important to you now is treatment for these alcohol problems?

☐ Not at all ☐ Slightly ☐ oderately ☐ onsiderably ☐ xtremely

26. **In the past 30 days,** have you used any of the following drugs?
(Not including drugs taken as prescribed by your doctor)

	NO	YES
a. Heroin.....	☐	☐
b. Methadone	☐	☐
c. Other opiates/analgesics *((Morphine; Dilaudid; Demerol; Percocet; Darvon; Talwin; Codeine; Tylenol 2,3,4; Syrups, Robittusin, Fentanyl)*	☐	☐
d. Barbiturates *(Nembutal, Seconol, Tuinol, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinol)*.....	☐	☐
e. Sedatives/Hypnotics/Tranquilizers *(Valium, Xanax, Librium, Ativan, Serax, Quaaludes, Tranxene, Dalmane, Halcion, Miltown)*.....	☐	☐
f. Cocaine *(Cocaine Crystal, Free-Base Cocaine, or "Crack" or "Rock")*	☐	☐
g. Amphetamines *(Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal)*	☐	☐
h. Cannabis *(Marijuana, Hashish, Pot)*.....	☐	☐
i. Hallucinogens *(LSD [Acid], Mescaline, Mushrooms [Psilocybin], Peyote,*	☐	☐

Green, PCP [Phencyclidine], Angel Dust, Ecstasy.....

27. How many days have you used more than one substance (including alcohol) **in the past 30 days?**..... _____ **number of days**

28. **In the past 30 days,** how many days have you experienced drug problems? _____ **number of days**

29. How troubled or bothered have you been by these drug problems **in the past 30 days?**

☐ **Not at all** ☐ **Slightly** ☐ **Moderately** ☐ **Considerably** ☐ **Extremely**

30. How important to you now is treatment for these drug problems?

☐ **Not at all** ☐ **Slightly** ☐ **Moderately** ☐ **Considerably** ☐ **Extremely**

PART V: YOUR LEGAL SITUATION

31. Are you presently awaiting charges, trial or sentence?..... ☐ **NO** ☐ **YES**

32. How serious do you feel your present legal problems are?

☐ **Not at all** ☐ **Slightly** ☐ **Moderately** ☐ **Considerably** ☐ **Extremely**

33. How important to you now is counseling or referral for these legal problems?

☐ **Not at all** ☐ **Slightly** ☐ **Moderately** ☐ **Considerably** ☐ **Extremely**

34. Have you been in a controlled environment **in the past 30 days?**

☐ **NO**

☐ **YES, jail**

☐ **YES, alcohol or drug treatment**

☐ **YES, medical treatment**

☐ **YES, psychiatric treatment**

☐ **YES, other (SPECIFY)** _____

35. How many days were you living in a controlled environment **in the past 30 days?** _____ **number of days**

36. What is today's date? _____ **Month** **Day** **Year**

Thank you for helping us improve our services.

HIPPA

Notice of Health Information Privacy Practices

This notice describes how health information about you may be used or disclosed by Northwest Arkansas Psychological Group and how to access this information.

Effective Date: April 14th, 2003

If you have any questions about this notice, please contact our office at (479) 442-9381.

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

We understand that health information about you and your healthcare is personal. We are committed to protecting health information about you. We will create a record of the care and services you receive from us. We do so to provide you with quality care and to comply with any legal or regulatory requirements.

This Notice applies to all of the records generated or received by Northwest Arkansas Psychological Group, whether we documented the health information, or another doctor forwarded it to us. This Notice will tell you the ways in which we *may* use or disclose health information about you. This Notice also describes your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

Our pledge regarding your health information is backed-up by Federal law. The privacy and security provisions of the Health Insurance Portability and Accountability Act ("HIPAA") require us to:

- Make sure that health information that identifies you is kept private;
- Make available this notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we may use or disclose health information about you. Unless otherwise noted each of these uses and disclosures may be made without your permission. For each category of use or disclosure, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, unless we ask for a separate authorization, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use health information about you to provide you with healthcare treatment and services. We may disclose health information about you to doctors, nurses, technicians, health students, volunteers or other personnel who are involved in taking care of you. They may work at our offices, at a hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy, or other healthcare provider to whom we may refer you for consultation, to perform tests, to have prescriptions filled, or for other treatment purposes. We may provide that information to a physician treating you at another institution.

For Payment: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, a state Medicare agency, or a third party. For example, we may need to give your health insurance plan information about your diagnosis so your health plan will pay us or reimburse you for the visit. Alternatively, we may need to give your health information to the state Medicare agency so that we may be reimbursed for providing services to you. In some instances, we may need to tell your health plan about a service you are going to receive to obtain prior approval or to determine whether your plan will cover the service.

For Healthcare Operations: We may use and disclose health information about you for operations of our healthcare practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study healthcare delivery without learning who our specific patients are.

For Appointment Reminders: We may use and disclose health information about you to contact you as a reminder that you have an appointment. Please let us know if you do not wish to have us contact you concerning your appointment, or if you wish to have us use a different telephone number or address to contact you for this purpose.

Research: There may be situations where we want to use and disclose health information about you for research purposes. For example, a research project may involve comparing the efficacy of one medication over another. For any research project that uses your health information, we will either obtain an authorization from you or ask an Institutional Review or Privacy Board to waive the requirement to obtain authorization from you. A waiver of authorization will be based upon assurances from a review board that the researchers will adequately protect your health information.

As Required By Law: We will disclose health information about you when required to do so by federal, state, or local law.

To Prevent a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans: If you are a member of the armed forces or are separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health activities.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to an order issued by a court or administrative tribunal. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only after efforts have been made to tell you about the request and you have time to obtain an order protecting the information requested, or unless you have signed an authorization permitting the disclosure.

Law Enforcement: We may release health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- If you are the victim of a crime and we are unable to obtain your consent;
- About a death we believe may be the result of criminal conduct;
- In an instance of criminal conduct at our facility; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Such releases of information will be made only after efforts have been made to tell you about the request and you have time to obtain an order protecting the information requested.

Coroners, Health Examiners, and Funeral Directors: We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary:

- For the institution to provide you with healthcare;
- To protect your health and safety or the health and safety of others; or
- For the safety and security of the correctional institution.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have certain rights to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records. ***This does not include psychotherapy notes.***

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing on a form provided by us to "The Privacy Official at Northwest Arkansas Psychological Group." If you request a copy of your health information, we may charge a fee for the costs of locating, copying, mailing or other supplies and services associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may in certain instances request that the denial be reviewed. Another licensed healthcare professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your initial request. We will comply with the outcome of the review.

Right to Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing on a form provided by us and submitted to: "The Privacy Official at Northwest Arkansas Psychological Group."

We may deny your request for an amendment if it is not the form provided by us and does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for our practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request a list (accounting) of any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

To request this list of disclosures, you must submit your request on a form that we will provide to you. Your request must state a time period that may not be longer than six years and may not include dates before April 14th, 2003 [The compliance date of the Privacy Regulation]. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date should not exceed a total of 60 days from the date you made the request. You may withdraw or modify your request at any time.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. For example, you

could ask that access to your health information be denied to a particular member of our workforce who is known to you personally. *While we will try to accommodate your request for restrictions, we are not required to do so if* it is not feasible for us to ensure our compliance with law or we believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request on a form that we will provide you. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain manner or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box. During our intake process, we will ask you how you wish to receive communications about your health care or for any other instructions on notifying you about your health information. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this Notice at any time upon request. You may also obtain a copy of this Notice at our website, if and when one exists.

CHANGES TO THIS NOTCE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in our facility. The Notice contains the effective date on the first page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact "The Privacy Official at Northwest Arkansas Psychological Group." All complaints must be submitted in writing. ***You will not be penalized for filing a complaint.***

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain the records of the care that we provided to you.