PATHWAYS TO CHANGE, LLC

DORICE NEIR, M.Ed, M.A., L.P.C.
2450 Atlanta Highway
Cumming, GA 30040

Acknowledgement of Receipt of Privacy Notice Form

Client Name/s

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise those rights and the practice's legal duties with respect to my protected health information.

I understand that this practice reserves the right to change the terms of its Privacy Practices and to make changes regarding all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature

_____

Date

Month Day Year

***If signed by Personal Representative, state relationship to client:**

CLIENT INFORMATION FORM

Today's date

Month Day Year

Name

Date of birth

Month Day Year

Home street address

City

State

Zip

Home/evening phone

Cell phone

Please enter a valid phone number.

Email

example@example.com

Calls and Email will be discreet, but please indicate any restrictions:

Spouse/partner

Children and their ages

Where do you get your medical care? Clinic and Doctor's name

Phone

If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call?

Name

Phone

Relationship

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before? If yes, please indicate when, for what, and for how long?

Have you ever taken medications for psychiatric or emotional problems? If yes, please indicate when, which medications, and for what?

Have you ever attempted suicide?

- ○ Yes
- ○ No

If "yes", when?

Have you ever abused any substance?

- ○ Yes
- ○ No

If "yes", when?

Please describe the main difficulty that has brought you to see me:

Please note: this is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Consent For Mental Health Services

I, the undersigned, agree and consent to participate in the

mental health services offered by DORICE NEIR, M.Ed., M.A.,

L.P.C., a mental health provider.

I understand that I am consenting and agreeing only to those

mental health services that the above-mentioned provider is

qualified to provide within the scope of the provider's licensure.

Signature

_____

Client's printed name

Date

Month Day Year

Counseling Policy Information

As you begin your counseling, there are a few items of information that you need to know. If at any time you have further questions, you may call me at 770-203-9060.

1.Please be informed if you have to cover a deductible amount before your insurance coverage for the counseling sessions is allowed. If it is not completely covered please be prepared to pay a fee for the sessions agreed upon by you and myself according to a sliding scale. The counselor will submit claims for these sessions so that they will be credited to your deductible amount.

2. If your insurance policy requires a copay please be prepared to pay at the time of the counseling sessions either by cash or check.

3. The counselor will take the responsibility for submitting all insurance claims.

1. If you find it necessary to cancel an appointment it is very helpful to give at least 24-hour notice. However, should last-minute unforeseen circumstances occur, a phone call explaining your situation with a request for rescheduling is all that is required.

2.The counselor will determine counseling hours and is responsible for scheduling the appointments.

3. The counselor reserves the right to consult with other counselors and/or supervisors about individual cases without revealing names or times. This right may be waived if requested by a

4. All client records (client-counselor contacts) are held confidential and are the property of the counselor.

Signature

_____

Date

Month Day Year

As you begin your counseling, there are a few items of information that you need to know. If at any time you have further questions, you may call me at 770-203-9060.

1.The client's fee is based upon a sliding fee scale that is based on your family's gross income. The counselor will retain the right to assess a client's financial status and personal considerations and make fee adjustments that are fair to both the client and the counselor.

2. Payment of fees will be made in accordance with the financial policy. A written copy of this financial policy will be explained to each client. The client will be asked to sign this agreement at the initial consultation.

3. Your fee per session had been established at $ Your counselor will receive your payment at each session. Any questions about changes in fees should be discussed with your counselor.

4. If you find it necessary to cancel an appointment it is very helpful to give 24-hour notice. However,

should last-minute unforeseen circumstances occur, a phone call explaining your situation with a request for rescheduling is all that is required.

5. The counselor will determine counseling hours and is responsible for scheduling the appointments.

6. The counselor reserves the right to consult with other counselors and/or supervisors about individual cases. This right may be waived if requested by a client.

7. All client records (all client-counselor contacts) are held confidential and are the property of the counselor.

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I care about my patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that I issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact Dorice Neir.

Any health care professional authorized to enter information into your medical record, at this practice, who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes, or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared. How We May Use and Disclose Medical Information About You The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding

- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under H1PAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

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

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with me or the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information I use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. I am not required to agree to your request. If I do agree, I will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to me. In your request, you must tell me what information you want to limit.

Right to Request Confidential Communications. You have the right to request how I should send communications to you about

medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to me. I will not ask you the reason for your request. I will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. I reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to me. If you request a copy of the information, I reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. I may deny your request to inspect and copy, in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied

your request. I will comply with the outcome of the review.

Right to Amend. If you feel that the medical information I have about you is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to me at this practice. In addition, you must provide a reason that supports your request. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request if the information was not created by me, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which I deem to be accurate and complete. If I deny your request for amendment, you have the right to file a statement of disagreement with me. I may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures I made of medical information about you. To request this list, you must submit your request to me at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years. Your request should indicate in what form you want the list (example: on paper or electronically The first list you request within a 12-month period will be free. For additional lists, I reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from me at this practice.

Changes to this Notice. I reserve the right to change this Notice. | reserve the right to make the revised or changed Notice effective for medical information I already have about you as well as any information I receive in the future. I will post a copy of the current Notice with the effective date in the upper right corner of the first page.

Signature

_____

Date

Month Day Year