

JULIE M. HALL, M.D.
Child, Adolescent, and Adult Psychiatrist

Hello.

I want to acknowledge you for taking steps towards improvement, and I appreciate the opportunity to you help you in this process. Prior to your initial appointment, please take the time to thoroughly review the following forms. Some forms are unique to my practice to facilitate a collaborative and streamlined working process. Other forms are requirements for all medical practices. By filling these forms out ahead of time, we will be able to make the most out of our first visit.

Forms you will find in this packet:

Information Form - basic information for your electronic record

Notice of Privacy Practices (5 pages) - required for all medical practices, providing information regarding how protected health information is shared and your rights

Authorization for Use or Disclosure of PHI - HIPAA (2 pages) - optional, but required if you would like for me to communicate about your treatment to others, such as other Physicians involved in your care, family members or friends. A separate consent is needed for each person that you would like me to be in contact with.

Consent for Email and/or Text Message Communication - optional, but required if you would like to communicate via email or text messaging. Otherwise all communication will be during scheduled appointments, by phone, or U.S. mail. In order to receive invoices by email, this form does need to be filled out and signed.

Credit Card Authorization - optional, but required if you are planning on using a credit card for payment and require a receipt of your transactions. If someone else is responsible for paying for services, then I ask that an authorization form be kept on file, even if other arrangements have been made.

Treatment Agreement (2 pages) - please review and sign

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To save time at your initial consultation, please have the following information available for entry into your electronic record. A copy of this form will not be kept in your record once the information is entered.

Name Nickname (if preferred)

Date of Birth Gender Marital Status Employment Status

Mailing Address

Phone numbers

Email address (separate consent form needed)

Pharmacy Information

Emergency Contact and Contact Information

Primary Care Provider and Contact Information

Current Medications and Prescriber Names

Notice of Privacy Practices

JULIE M. HALL, M.D.

Child, Adolescent, and Adult Psychiatrist

Your Information. Your Rights. Our Responsibilities.

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.

Overview

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that this practice uses and shares information, including:

- Telling family and friends about your condition
- Providing mental health care

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Comply with the law
- Work with a medical examiner
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

Effective Date of this Notice: September 1, 2016

For questions regarding this Notice, please contact Julie M. Hall, M.D. directly.

We never market or sell personal information.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

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Notice of Privacy Practices (continued, 2 of 5)

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless we have your written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you. Example: Your primary care physician shares information with this practice regarding recent changes to your medications.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Examples: We will provide an invoice or Superbill to you that you may submit to your insurance for reimbursement. We will contact your health plan to obtain prior authorization for a medication that is not currently covered.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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Child, Adolescent, and Adult Psychiatrist

Authorization for Release of Information

Full Name	Date of Birth	Telephone number
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Address	City	State	Zip Code
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I hereby authorize use or disclosure of protected health information about me as described below:

1. Dr. Julie M. Hall is authorized to use or disclose information about me.
2. The following person (or class of persons) may receive disclosure of protected health information about me:

Name of Person or Entity	Relationship	Telephone number
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Address	City	State	Zip Code
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3. I understand that this information will be used for my treatment with Dr. Julie M. Hall. I also understand that this release authorizes disclosure of information regarding mental health, substance abuse, medical health, social history, and treatment. I also understand that I may revoke this consent at any time but that it remains in effect until further notice.

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying Julie M. Hall, M.D. in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Signature of Patient/Guardian	Relationship to Patient
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Printed Name	Date
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Consent for Email and/or Text Message Communication

Email and text messaging allows health care providers to exchange information efficiently for the benefit of our patients. At the same time, we recognize that email and text messaging are not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or during transmission.

HIPAA requires that providers take reasonable steps to protect against these risks but acknowledges that a balance must be struck between the need to secure protected health information (PHI) and the need to ensure that clinicians can efficiently exchange important patient care information. My practice has implemented such measures through obtaining informed consent from patients using any potentially unencrypted electronic format.

Please practice discretion and best judgment when using email or text messaging. Most common and appropriate uses of these forms of communication include:

- 1) Scheduling or rescheduling of appointments
- 2) Prescription related issues
- 3) Brief clinical questions
- 4) Billing related communication - including the sending of invoices and Superbills

Email or text messaging should not be used for:

- 1) Emergency situations. Under these circumstances, call 911
- 2) Disclosure of sensitive information that should otherwise be discussed during regular appointments

If you would like to use email and/or text messages that may contain your protected health information please complete and sign this Consent below. You are not required to authorize the use of email and/or text messaging and a decision not to sign this authorization will not affect your health care in any way. If you prefer not to authorize the use of email and/or text messaging I will continue to use U.S. Mail or telephone to communicate with you.

Signature

Date

Name (please print)

Personal email address where Dr. Julie M. Hall may send you your health information (please print)

Telephone number where Dr. Julie M. Hall may text you your health information (please print)

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Credit Card Processing Agreement

Name:

Payor's Name (if different than the above): _____

Credit Card Number

Security Code (3 digits for Visa, MC, Discover; 4 digits for Amex) / Expiration Date / Billing Zip Code

Email address or text message phone number for transaction receipts

I hereby authorize Julie M. Hall, M.D. to use the above credit card, including circumstances where the credit card is not present. This credit card can be used to pay for services rendered and for any outstanding balances on this client/patient's account. Charges will be made for services as described in the "Fee Schedule," including fees for scheduled appointments, charges for missed appointments or late cancelations, and for fees associated with services provided outside of scheduled appointment times. This authorization is good through the credit card expiration date.

If charges are disputed and reported to your credit card company, I agree to allow Julie M. Hall, M.D. to contact my credit card company and disclose the purposes of the disputed charges, which may include information regarding attendance or cancellations of appointments.

Authorized Signature Date

JULIE M. HALL, M.D.

Child, Adolescent, and Adult Psychiatrist

Practice Agreement

Appointments - Office hours are by appointment only. The initial evaluation is scheduled for 90 minutes to 120 minutes. Therapy sessions are scheduled for 60 minutes. Follow up medication visits are scheduled for up to 30 minutes. Couples therapy sessions are scheduled for 60 minutes. The appointment time is reserved for you, so it is important that you are on time. If you are late, your appointment may still conclude at the end of your scheduled appointment, or your appointment may have to be forfeited. I keep this policy so that I remain prompt and on time for all my clients. However, if I am running late for your appointment, you will still receive the full time that was allotted for your visit. Any significant additional time requested outside of scheduled appointments will be billed in 15 minute increments. This includes phone or email consultations, filling out forms, writing letters, review of outside records, or other administrative tasks.

24 Hour Cancellation Policy - As stated above, appointment times are reserved for you. If you cannot make your appointment, please call to cancel or reschedule as soon as possible, giving a minimum 24 hours notice. If you do not come to your appointment, or cancel less than 24 hours beforehand, then you will be charged at your regular customary fee for your missed session. I keep this policy in part so that cancelled appointment times become available for others who otherwise might not be seen when my schedule is full.

Record Keeping & Confidentiality - A chart in your name is maintained describing your condition, and progress, and if applicable diagnosis and treatment. An entry is made for each appointment. The information that is contained in your record will not be released without your written consent except in the circumstances outlined below and explained in detail in the Notice of Privacy Practices. Medical records are kept electronically with appropriate security precautions. All information discussed in your session is confidential with certain exceptions required by law. These exceptions include: 1) imminent danger to yourself or another person; 2) abuse or suspected abuse of a child, an elderly or disabled person; and 3) if your records are subpoenaed by the court. If you are using your insurance company for reimbursement, they may require a diagnosis and may even request treatment information or copies of your chart. I am obligated to provide this to them if you wish to be reimbursed.

Use of Medical Insurance & Payments - All visits must be paid for at the time of the visit (cash, check, or credit card). There will be a \$25 fee charged for all returned checks, and a credit card will then be required to be kept on file. I am not an insurance provider on any private medical insurance plans; I am also not a Medicare or MediCal provider. If your private insurance plan will reimburse a portion of the fees for out-of-network providers, you will be provided a statement, which can be submitted to your insurance company. You will be reimbursed directly by your insurance plan. Medicare beneficiaries must agree to a separate "private contract" in order to receive services, and cannot submit claims or seek reimbursement from Medicare, even if you have supplemental insurance. I cannot accept responsibility for submitting or negotiating claims with insurance companies, Medicare, MediCal or other parties. You are responsible for payment of your medical care regardless of the status of your claim. Any other financial arrangement must be made prior to service. If a balance accrues for greater than 30 days, then future appointments may be temporarily

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Practice Agreement (continued)

suspended until the balance is paid in full. If needed, some prescriptions may be provided in the interim. An inability to pay your balance in a timely manner may be reason to terminate our relationship, at which time you will be given referrals to other treatment providers and some limited prescriptions if necessary. You are still responsible for payment of your balance in full.

Fees- Fees are adjusted periodically, no more than once per year. You will always be informed prior to any fee changes.

Current fees are as follows:

Hourly rate (60 minutes) \$600

Initial Consultation (90 minutes-120 minutes) \$900 or \$1200 respectively

Brief Therapy with Medication Evaluation (30 minutes) \$300

Individual Therapy (60 minutes) \$600

Administrative Time, i.e. writing letters, filling out forms, phone or email consultations (per 15 minutes) \$80

Late Cancellations or Missed Appointments \$300, \$600

Late cancellations or missed appointments are billed based on the scheduled appointment time.

Prescriptions - It is my policy to write prescriptions and refills when you come for a scheduled appointment. In emergency cases, I may authorize some medication prior to your next appointment. It is a shared responsibility between both patient and provider to monitor medication refills, so as to minimize the need for prescribing medication outside of office appointments.

Communication Outside of Appointment Times and Emergency Availability -

Messages can be left on my voicemail at (424) 256-6890. Messages are generally returned within one to two business days, depending on the urgency of the matter. If left on a non-business day, such as weekends or holidays, messages will be returned on a business day. I may also be contacted by email or text messaging as outlined in the *Consent for Email and/or Text Message Communication* form. In the case of a true emergency, I can be reached by calling (424) 256-6890. If I am not available for an extended period of time, I will always arrange for a psychiatrist to cover my practice.

By signing below, you agree to the above Practice Agreement. You are also acknowledging that you have received a copy of the Notice of Privacy Practices.

Name (please print)

Signature

Date

Please keep a copy of this Practice Agreement and the Notice of Privacy Practices for your own records.