



# Responsive Centers for Psychology & Learning

7501 College Boulevard, Suite 250 ♦ Overland Park, Kansas 66210

Telephone: (913) 451-8550 ♦ Fax: (913) 469-5266

## CLIENT REGISTRATION FORM – SUE NOLAN, M.A./LIZ SWANSON-HYLAND, PH.D.

Clinician Seen: \_\_\_\_\_

### **CLIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone (Mom): \_\_\_\_\_ Cell Phone (Dad): \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher's Name: \_\_\_\_\_ Counselor's Name: \_\_\_\_\_

Referred by: \_\_\_\_\_ Physician \_\_\_\_\_ Family Member \_\_\_\_\_ School \_\_\_\_\_ Friend \_\_\_\_\_ Other: \_\_\_\_\_

### **FINANCIALLY RESPONSIBLE PARTY** (adult who brings the client to the appointment)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip

Employer: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

### **FINANCIAL POLICY** (adult who brings the client to the appointment)

Payment in full is due at the time of service. All payments will be collected at check-in during regular business hours. Anytime our receptionist is not available, please place your payment in the locked box to the left of the receptionist's window in the waiting room, or pay your clinician immediately following your visit.

If you fail to notify the office of a cancellation 24 hours prior to your scheduled visit, you may be charged for the visit.

I have read and understand the above stated policies.

\_\_\_\_\_  
Printed Name Signature Date



# Responsive Centers for Psychology & Learning

7501 College Boulevard, Suite 250 ♦ Overland Park, Kansas 66210

Telephone: (913) 451-8550 ♦ Fax: (913) 469-5266

## CLIENT INTAKE AND DEVELOPMENTAL HISTORY

Clinician Seen: Susan M. Nolan, MA.

Date: \_\_\_\_\_ Form Completed by: \_\_\_\_\_ Referred by: \_\_\_\_\_

**Client's Name:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Current Grade: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip Does client have cell phone?

Home Phone: \_\_\_\_\_ Cell Phone (Mom): \_\_\_\_\_ Cell Phone (Dad): \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

May we contact you at work?  Yes  No Work Phone (Mom): \_\_\_\_\_ Work Phone (Dad): \_\_\_\_\_

May we contact you by personal e-mail?  Yes  No E-Mail Address: \_\_\_\_\_

Are parents married?  Yes  No Separated?  Yes  No Divorced?  Yes  No

Client resides with: \_\_\_\_\_ Is client adopted?  If yes, age/conditions when adopted: \_\_\_\_\_

**School:** \_\_\_\_\_ Teacher's Name: \_\_\_\_\_ Counselor's Name: \_\_\_\_\_

School Address: \_\_\_\_\_  
Street City State Zip

School Phone: \_\_\_\_\_ School Fax: \_\_\_\_\_

### Mother's Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(If different than above)

Age: \_\_\_\_\_ Education (years): \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Type of Employment: \_\_\_\_\_

### Father's Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(If different than above)

Age: \_\_\_\_\_ Education (years): \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Type of Employment: \_\_\_\_\_

Please list all other children in the family (including step siblings): Age: Grade: List other people living with the family:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

1. Describe the nature of your current concerns and why you are seeking help:

---

---

---

---

2. Has there been previous testing that resulted in a diagnosis? \_\_\_\_\_ If yes, what type? \_\_\_\_\_  
(Please provide copies of any previous test reports or assessment results)

---

---

3. When diagnosed? \_\_\_\_\_ By whom? \_\_\_\_\_

4. What type of support has the client qualified for at school and what types of services have been provided?

---

---

**Current Physician's Name:** \_\_\_\_\_

Physician's Address: \_\_\_\_\_  
Street City State Zip

Physician's Phone: \_\_\_\_\_ Physician's Fax: \_\_\_\_\_

List other physicians or specialists that treat the client:

---

---

Past medication and dosage prescribed? Was it effective? (Please list the medication history/dosage and conditions) \_\_\_\_\_

---

---

---

Current Medication and Dosage: \_\_\_\_\_

---

---

Please describe the dates and nature of any past services and who provided them:

Counseling: \_\_\_\_\_

Therapy: \_\_\_\_\_

Other: \_\_\_\_\_

## SCHOOL HISTORY

---

1. Summary of school progress (e.g., schools attended, academic, social, testing) within each of these grade levels:

Preschool: \_\_\_\_\_

Kindergarten: \_\_\_\_\_

Grades 1 through 3: \_\_\_\_\_

Grades 4 through 6: \_\_\_\_\_

Grades 7 through 12: \_\_\_\_\_

College: Degree/Date of Graduation: \_\_\_\_\_

2. Has the client ever been in any type of special education program, and if so, how long?

Notes on:

Which district, agency, or individual provided specialized services?

Learning disabilities class: \_\_\_\_ Yes \_\_\_\_ No

If Yes, dates and duration of placement: \_\_\_\_\_

Behavioral/emotional disorders class: \_\_\_\_ Yes \_\_\_\_ No

If Yes, dates and duration of placement: \_\_\_\_\_

Resource room: \_\_\_\_ Yes \_\_\_\_ No

If Yes, dates and duration of placement: \_\_\_\_\_

Speech and language therapy: \_\_\_\_ Yes \_\_\_\_ No

If Yes, dates and duration of therapy: \_\_\_\_\_

Occupational or physical therapy: \_\_\_\_ Yes \_\_\_\_ No

If Yes, dates and duration of therapy: \_\_\_\_\_

Tutoring: \_\_\_\_\_

Summer School: \_\_\_\_\_

3. Is the client right handed or left handed? \_\_\_\_\_

Does the client wear glasses? \_\_\_\_ Yes \_\_\_\_ No Condition: \_\_\_\_\_ Age diagnosed: \_\_\_\_\_

4. Current accommodations or individualized support: (Attach a copy of current IEP or accommodation plan, if available)

**5. Current Academic Information:**

Subject	Below Grade Level	At Grade Level	Above Grade Level	Observations and Teacher Comments
Reading				
Math				
Social Studies				
Science				
Writing				
Spelling				
Other				

Please use the space below, if needed, in order to better describe any specific problems or patterns of difficulties the client has experienced academically. Feel free to include any comments teachers have made or attach any examples of testing or work that shows where there are academic difficulties or inconsistencies.

**SOCIAL HISTORY**

**Comments and Notes**

1. How does the client get along with his/her brothers/sisters?

- Doesn't have any \_\_\_\_\_
- Better than average \_\_\_\_\_
- Average \_\_\_\_\_
- Worse than average \_\_\_\_\_

2. How easily does the client make friends?

- Easier than average \_\_\_\_\_
- Average \_\_\_\_\_
- Harder than average \_\_\_\_\_
- Don't know \_\_\_\_\_

3. On average, how long does the client keep friendships?

- Less than 6 months \_\_\_\_\_
- 6 months – 1 year \_\_\_\_\_
- More than 1 year \_\_\_\_\_
- Don't know \_\_\_\_\_

4. Describe any additional information on ability to make and maintain social relationships:

At home: \_\_\_\_\_

At school/work: \_\_\_\_\_

5. Describe involvement in outside activities:

Sports: \_\_\_\_\_ Music: \_\_\_\_\_ Clubs: \_\_\_\_\_ Scouts: \_\_\_\_\_ Church: \_\_\_\_\_

Please describe other special interests or hobbies: \_\_\_\_\_

6. Have any of the following stress events occurred within the past 12 months?

- Parents divorced or separated \_\_\_\_\_
- Family accident or illness \_\_\_\_\_
- Death in the family \_\_\_\_\_
- Parent changed jobs \_\_\_\_\_
- Child changed schools \_\_\_\_\_
- Family moved \_\_\_\_\_
- Family financial problems \_\_\_\_\_
- Other (please specify) \_\_\_\_\_

**BEHAVIORAL HISTORY**

1. Check each of the following as it applies:

	Yes	No	Sometimes	Comments
Truthful				
Daydreams				
Withdrawn				
Sense of humor				
Outgoing				
Shy				
Nervous				

Check each of the following as it applies	Yes	No	Sometimes	Comments
Easily frustrated or upset				
Inability to control temper				
Difficulty adjusting to changes				
Difficult to discipline				
Stealing				
Overactive				
Short attention span				
Difficulty following directions				
Respect for authority figures				
Good self concept				
Follows through with responsibilities				
Self help skills adequate				

2. Describe any behavioral concerns:

Other (Related) Concerns:

Has the client ever talked about dying or attempted suicide?

Has the client ever been:

3. Suspended from school: \_\_\_Yes \_\_\_No Expelled from school: \_\_\_Yes \_\_\_No Retained in grade: \_\_\_Yes \_\_\_No

Explain circumstances:

4. Have there been difficulties related to substance use? \_\_\_Yes \_\_\_No Involvement in sexual abuse? \_\_\_Yes \_\_\_No

Explain circumstances:

5. Had legal difficulties or been arrested? \_\_\_Yes \_\_\_No

Explain circumstances:

6. Have any behavior modifications been attempted? \_\_\_Yes \_\_\_No

Behavior modification program: \_\_\_Yes \_\_\_No Daily/weekly/report card: \_\_\_Yes \_\_\_No

Other (please specify): \_\_\_\_\_

7. What other strategies have been implemented to address behavior? (Check all which have been successful)

- Verbal reprimands: \_\_\_\_\_ Physical punishment: \_\_\_\_\_
- Acquiescence to client: \_\_\_\_\_ Time out (isolation): \_\_\_\_\_
- Removal of privileges: \_\_\_\_\_ Rewards: \_\_\_\_\_
- Avoidance of client : \_\_\_\_\_ Professional intervention: \_\_\_\_\_
- Other: \_\_\_\_\_

8. On average, what percentage of the time does the client eventually comply with commands?

0-20%: \_\_\_\_\_ 20-40%: \_\_\_\_\_ 40-60%: \_\_\_\_\_ 60-80%: \_\_\_\_\_ 80-100%: \_\_\_\_\_

9. To what extent are you and your spouse consistent with respect to disciplinary strategies?

Most of the time: \_\_\_\_\_ Some of the time: \_\_\_\_\_ None of the time: \_\_\_\_\_

**DEVELOPMENTAL AND MEDICAL HISTORY**

**HEALTH HISTORY**

- A. Date of the client’s last physical exam: \_\_\_\_\_ Explain/Note Circumstances
- B. At any time has the client had any of the following?
- |   |             |            |               |       |
|---|-------------|------------|---------------|-------|
| 1. Asthma:  | _____ Never | _____ Past | _____ Present | _____ |
| 2. Allergies:   | _____ Never | _____ Past | _____ Present | _____ |
| 3. Diabetes, arthritis, or other chronic illnesses:               | _____ Never | _____ Past | _____ Present | _____ |
| 4. Epilepsy or seizure disorder:                                  | _____ Never | _____ Past | _____ Present | _____ |
| 5. Febrile seizures:  | _____ Never | _____ Past | _____ Present | _____ |
| 6. Chicken pox or other common childhood illnesses:               | _____ Never | _____ Past | _____ Present | _____ |
| 7. Heart or blood pressure problems:                              | _____ Never | _____ Past | _____ Present | _____ |
| 8. Broken bones:  | _____ Never | _____ Past | _____ Present | _____ |
| 9. Severe cuts requiring stitches:                                | _____ Never | _____ Past | _____ Present | _____ |
| 10. Head injury with loss of consciousness:                       | _____ Never | _____ Past | _____ Present | _____ |
| 11. Lead poisoning:   | _____ Never | _____ Past | _____ Present | _____ |
| 12. Surgery:  | _____ Never | _____ Past | _____ Present | _____ |
| 13. Lengthy hospitalization:                                      | _____ Never | _____ Past | _____ Present | _____ |
| 14. Speech or language problems:                                  | _____ Never | _____ Past | _____ Present | _____ |
| 15. Chronic ear infections:                                       | _____ Never | _____ Past | _____ Present | _____ |
| 16. Hearing difficulties:   | _____ Never | _____ Past | _____ Present | _____ |
| 17. Eye or vision problems:                                       | _____ Never | _____ Past | _____ Present | _____ |
| 18. Eye glasses/contact lenses:                                   | _____ Never | _____ Past | _____ Present | _____ |
| 19. Appetite problems (over eating or under eating):              | _____ Never | _____ Past | _____ Present | _____ |
| 20. Sleep problems (falling asleep, staying asleep):              | _____ Never | _____ Past | _____ Present | _____ |
| 21. Soiling problems:   | _____ Never | _____ Past | _____ Present | _____ |
| 22. Wetting problems:   | _____ Never | _____ Past | _____ Present | _____ |
| 23. Sensory Integration problems:                                 | _____ Never | _____ Past | _____ Present | _____ |
| 24. Other developmental delays, health difficulties, or concerns: |             |            |               | _____ |

Please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PREGNANCY AND DELIVERY**

- A. Length of pregnancy (e.g., full term, 40 weeks, 32 weeks, etc.): \_\_\_\_\_
- B. Length of delivery (number of hours from initial labor pains to birth): \_\_\_\_\_
- C. Mother’s age when client was born: \_\_\_\_\_
- D. Client’s birth weight: \_\_\_\_\_
- E. Did any of the following conditions occur during pregnancy/delivery?
- |   |          |           |
|---|----------|-----------|
| 1. Bleeding:                                    | _____ No | _____ Yes |
| 2. Excessive weight gain (more than 30 lbs):    | _____ No | _____ Yes |
| 3. Toxemia/preeclampsia:                        | _____ No | _____ Yes |
| 4. Rh factor incompatibility:                   | _____ No | _____ Yes |
| 5. Frequent nausea or vomiting:                 | _____ No | _____ Yes |
| 6. Serious illness or injury:                   | _____ No | _____ Yes |
| 7. Took prescription medication(s):             | _____ No | _____ Yes |
| If yes, name of medication(s): _____            |          |           |
| 8. Took illegal drugs:                          | _____ No | _____ Yes |
| 9. Used alcoholic beverages:                    | _____ No | _____ Yes |
| If yes, approximate # of drinks per week: _____ |          |           |

E. Did any of the following conditions occur during pregnancy/delivery? (cont.)

10. Smoked cigarettes: \_\_\_\_\_ No \_\_\_\_\_ Yes

If yes, approximate # of cigarettes per day (e.g., 1/2 pack): \_\_\_\_\_

11. Was medication given to ease labor pains? \_\_\_\_\_ No \_\_\_\_\_ Yes

If yes, name of medication: \_\_\_\_\_

12. Delivery was induced: \_\_\_\_\_ No \_\_\_\_\_ Yes

13. Forceps used during delivery: \_\_\_\_\_ No \_\_\_\_\_ Yes

14. Had a breech delivery: \_\_\_\_\_ No \_\_\_\_\_ Yes

15. Had a caesarean delivery: \_\_\_\_\_ No \_\_\_\_\_ Yes

16. Other problems: \_\_\_\_\_ No \_\_\_\_\_ Yes

If yes, please describe: \_\_\_\_\_

F. Did any of the following conditions affect the client during delivery, or within the first few days after birth?

1. Injured during delivery: \_\_\_\_\_ No \_\_\_\_\_ Yes

2. Cardiopulmonary distress during delivery: \_\_\_\_\_ No \_\_\_\_\_ Yes

3. Delivered with cord around the neck: \_\_\_\_\_ No \_\_\_\_\_ Yes

4. Had trouble breathing following the delivery: \_\_\_\_\_ No \_\_\_\_\_ Yes

5. Needed oxygen: \_\_\_\_\_ No \_\_\_\_\_ Yes

6. Was cyanotic, turned blue: \_\_\_\_\_ No \_\_\_\_\_ Yes

7. Was jaundiced, turned yellow: \_\_\_\_\_ No \_\_\_\_\_ Yes

8. Had an infection: \_\_\_\_\_ No \_\_\_\_\_ Yes

9. Had seizures: \_\_\_\_\_ No \_\_\_\_\_ Yes

10. Was given medications: \_\_\_\_\_ No \_\_\_\_\_ Yes

11. Born with congenital defect: \_\_\_\_\_ No \_\_\_\_\_ Yes

12. Was in hospital more than 7 days: \_\_\_\_\_ No \_\_\_\_\_ Yes

INFANT HEALTH AND DEVELOPMENT

Comments and Notes

During the first 12 months, was the client:

1. Difficult to feed: \_\_\_\_\_ No \_\_\_\_\_ Yes

2. Difficult to get to sleep: \_\_\_\_\_ No \_\_\_\_\_ Yes

3. Colicky: \_\_\_\_\_ No \_\_\_\_\_ Yes

4. Difficult to put on a schedule: \_\_\_\_\_ No \_\_\_\_\_ Yes

5. Alert: \_\_\_\_\_ No \_\_\_\_\_ Yes

6. Cheerful: \_\_\_\_\_ No \_\_\_\_\_ Yes

7. Affectionate: \_\_\_\_\_ No \_\_\_\_\_ Yes

8. Sociable: \_\_\_\_\_ No \_\_\_\_\_ Yes

9. Easy to comfort: \_\_\_\_\_ No \_\_\_\_\_ Yes

10. Difficult to keep busy: \_\_\_\_\_ No \_\_\_\_\_ Yes

11. Overactive, in constant motion: \_\_\_\_\_ No \_\_\_\_\_ Yes

12. Very stubborn, challenging: \_\_\_\_\_ No \_\_\_\_\_ Yes

Other observations: \_\_\_\_\_

EARLY DEVELOPMENTAL MILESTONES

At what age did the client first accomplish the following?

1. Sitting up without help: \_\_\_\_\_

2. Crawling: \_\_\_\_\_

3. Walking alone, without assistance: \_\_\_\_\_

4. Using single words (e.g., "mama," "dada," "ball," etc.): \_\_\_\_\_

5. Putting two or more words together (e.g., "mama up"): \_\_\_\_\_

6. Bowel training, day and night: \_\_\_\_\_

7. Bladder training, day and night: \_\_\_\_\_

## Family History

Please provide information regarding relatives (siblings, parents, grandparents, aunts, uncles, cousins, etc.) who have ever been identified with or suspected to have difficulty in these areas.

Client Registration Form – Sue Nolan/Liz Swanson-Hyland

Revised 11/2010

**List Relatives with**      **As a Child/as a Teen/**  
**History of Difficulty**      **as an Adult**

1. Oppositional behavioral or problems with aggressiveness and defiance now, or as a child
2. Problems with attention, level of activity, or impulse control now, or as a child
3. Learning disabilities
4. Developmental delays/mental retardation
5. Failed to graduate from high school
6. Depression for greater than 2 weeks
7. Anxiety disorder that impaired adjustment
8. Autism or Asperger's
9. Alcohol abuse
10. Substance Abuse
11. Tics or Tourette's
12. Antisocial behavior (assaults, thefts, arrests)
13. Psychosis or schizophrenia
14. Physical abuse
15. Sexual abuse
16. Other

**Please answer these questions**

**Comments and Notes**

1. Which of the following are considered to be a significant problem at the present time?

- Fidgets \_\_\_\_\_ No \_\_\_\_\_ Yes
- Difficulty remaining seated \_\_\_\_\_ No \_\_\_\_\_ Yes
- Easily distracted \_\_\_\_\_ No \_\_\_\_\_ Yes
- Difficulty awaiting turn \_\_\_\_\_ No \_\_\_\_\_ Yes
- Often blurts out answers to questions before they have been completed \_\_\_\_\_ No \_\_\_\_\_ Yes
- Difficulty following instructions \_\_\_\_\_ No \_\_\_\_\_ Yes
- Difficulty sustaining attention \_\_\_\_\_ No \_\_\_\_\_ Yes
- Shifts from one activity to another \_\_\_\_\_ No \_\_\_\_\_ Yes
- Difficulty playing quietly \_\_\_\_\_ No \_\_\_\_\_ Yes
- Often talks excessively \_\_\_\_\_ No \_\_\_\_\_ Yes
- Often interrupts/intrudes on others \_\_\_\_\_ No \_\_\_\_\_ Yes
- Often does not listen \_\_\_\_\_ No \_\_\_\_\_ Yes
- Often loses things \_\_\_\_\_ No \_\_\_\_\_ Yes
- Often engages in physically dangerous activities \_\_\_\_\_ No \_\_\_\_\_ Yes

2. When did these problems begin? Specify age: \_\_\_\_\_

3. Which of the following are considered to be a significant problem at the present time?

- Often loses temper \_\_\_\_\_ No \_\_\_\_\_ Yes
- Often argues with adults \_\_\_\_\_ No \_\_\_\_\_ Yes
- Often actively defies or refuses adult requests or rules \_\_\_\_\_ No \_\_\_\_\_ Yes
- Often deliberately does things that annoy other people \_\_\_\_\_ No \_\_\_\_\_ Yes
- Often blames others for own mistakes \_\_\_\_\_ No \_\_\_\_\_ Yes
- Is often touchy or easily annoyed by others \_\_\_\_\_ No \_\_\_\_\_ Yes
- Is often angry or resentful \_\_\_\_\_ No \_\_\_\_\_ Yes

From *Defiant Children* (2<sup>nd</sup> ed.): *A Clinician’s Manual for Assessment and Parent Training* by Russell A. Barkley. Copyright 1997 by the Guilford Press. Reprinted in: *A Clinical Workbook* (3<sup>rd</sup> ed.) by Russell A. Barkley and Kevin R. Murphy. Permission to photocopy this form is granted to purchasers of the *Workbook* for personal use only (see copyright page for details).



# Responsive Centers for Psychology and Learning

## Notice of Clinician's Policies and Practices to Protect the Privacy of Your Health Information:

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information.

### I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment, and Health Care Operations"*
  - *Treatment* is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another therapist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

### II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

### III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* - If I have reason to suspect that a child has been injured as a result of physical, mental or emotional abuse or neglect or sexual abuse, I must report the matter to the appropriate authorities as required by law.
- *Adult and Domestic Abuse* - If I have reasonable cause to believe that an adult is being or has been abused, neglected or exploited or is in need of protective services, I must report this belief to the appropriate authorities as required by law.
- *Health Oversight Activities* - I may disclose PHI to the Kansas Behavioral Sciences Regulatory Board if necessary for a proceeding before the Board.
- *Judicial and Administrative Proceedings* - If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* - If I believe that there is a substantial likelihood that you have threatened an identifiable person and that you are likely to act on that threat in the foreseeable future, I may disclose information in order to protect that individual. If I believe that you present an imminent risk of serious physical harm or death to yourself, I may disclose information in order to initiate hospitalization or to family members or others who might be able to protect you.
- *Worker's Compensation* - I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

**IV. Client's Rights and Clinician's Duties**

Client's Rights:

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* - You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Clinician's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a revised notice by U.S. Postal Service.

**V. Complaints**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact Dr. J. Stephen Hazel, Clinical Director of Responsive Centers at 913-451-8550 extension 108.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

**VI. Effective Date**

This notice will go into effect on April 14, 2003.

**I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND WHAT IT CONTAINS.**

Print Name	Signature	Date
------------	-----------	------

Signature of Witness	Date
----------------------	------

