Assessment and Therapy Associates of Grand Forks (ATAGF)
Bariatric Health Screening/Medical History

Name:_____ Date_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____(if unsure, best guess)

Personal Information:

Ethnicity/national origin: _____ Race: _____

Sexual orientation: _____

Religious denomination/affiliation:

□ Protestant □ Catholic □ Jewish □ Islamic □ Buddhist □ Other:_____

Involvement: □ None □ Some/irregular □ Active

Educational/Occupational:

Education: Grade School High School GED College Tech School Post Grad

Occupation/Employer: _____(full time_____Part time____)

Student_____ Disabled_____ Not employed _____

Relationship Status (please circle):

Single Married Separated Divorced Widowed Living with partner Dating

Spouse's/Significant Other's Name: _____

Children's Ages: Boys:_____ Girls: _____

Physician Information

Family Physician_____Phone Number_____

May we contact your family physician to coordinate your care? Yes_____ No _____

Family History (please check all that apply)

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Siblings	Children
Obesity								
Diabetes								
Heart disease								
Cancer								
Arthritis								
High Blood Pressure								

Medical History

Date of last physical:_____ Date of last visit to family M.D.: _____

Prescriptions (include all prescriptions, over the counter, and herbal medications)

Drug Name:	Milligram (mg) dosage:	How often:
Drug Name:	Milligram (mg) dosage:	How often:
Drug Name:	Milligram (mg) dosage:	How often:
Drug Name:	Milligram (mg) dosage:	How often:
Drug Name:	Milligram (mg) dosage:	How often:
Drug Name:	Milligram (mg) dosage:	How often:
Drug Name:	Milligram (mg) dosage:	How often:
Drug Name:	Milligram (mg) dosage:	How often:
Drug Name:	Milligram (mg) dosage:	How often:
Drug Name:	Milligram (mg) dosage:	How often:
Drug Name:	Milligram (mg) dosage:	How often:
Drug Name:	Milligram (mg) dosage:	How often:

Are you taking aspirin or ibuprofen for joint or back pain? Yes No

Substance Use

Do you consume alcohol? Yes No

Do you use tobacco? Yes No Are you a former smoker? Yes No Quit Date: _____

If you currently use tobacco, how much do you use? _____ When did you start smoking?_____

Do you use any form of street drugs? Yes No If so, what kind and how often?_____

_____

Surgical History

Procedure:	When:	Where:	Dr.
Procedure:	When:	Where:	Dr.
Procedure:	When:	Where:	Dr.
Procedure:	When:	Where:	Dr.
Procedure:	When:	Where:	Dr.
Procedure:	When:	Where:	Dr.

Dietary History

How many meals do you eat per day? _____

How many snacks and what kind of snacks do you eat each day?

How often do you dine out each week? _____ Type of Restaurant? _____

What are your favorite foods?

Please describe what you eat and when you eat it on a typical day (please be specific).

What beverages do you drink on a typical day?

Milk___ Soda___ Coffee____ Tea____ Fruit Juice_____ Water _____

What are your most difficult struggles with weight management/eating (circle as many that apply)?

Grazing Binge Eating Purging Portion Control Night Eating Other:

When did your obesity begin? _____ At what weight? _____

What was your **highest** weight in the last 12 months? _____ In the last 5 years? _____

What was your **lowest** weight in the last 12 months? _____ In the last 5 years? _____

What is your usual adult weight? _____

Are there any other things about your eating habits you wish to share?

Exercise

What kind of exercise/activity are you currently doing?

How many days per week? _____ For what length of time? _____

Are there any other things about your exercise habits you wish to share?

Are there any other questions or concerns we can answer during your visit?

Weight Loss Attempts

Program	**Year(s)**	**# of Months on Program**	**Weight Lost**	**How Long Loss Maintained**
Dr. Atkins				
Behavior Modification				
Diabetes Education				
Dietician				
Diet Center				
Exercise Program				
Jaws Wired				
Jenny Craig				
Medi-Fast				
Nutri System				
Nutritionist				
Opti-Fast				
Overeaters Anonymous				
Phen-Fen				
Physician-Directed Diet				
Prescribed Medication				
Psychological Treatment/Therapy				
Richard Simmons				
Slim Fast				
T.O.P.S.				
Weight Watchers				
Self-Monitored Diets				

List all doctors or clinics you have visited for weight problems. Include name, address, and types of treatments you have used. Please include all doctors with whom you have discussed your weight.

Prescribing Doctor/Clinic	Address	Treatment Dates	Type (pills, shots, etc.)

Have you had a surgical procedure specifically for obesity or morbid obesity? Yes No

If yes, what procedure did you have?

Where did you have this procedure, and by whom?

How much weight did you lose? _____ When did you start to regain weight? _____

ASSESSMENT AND THERAPY ASSOCIATES OF GRAND FORKS (ATAGF), PLLC
PATIENT SERVICES AGREEMENT

****Please note that your signature is needed on pages 6 and 7 of this Agreement.****

Welcome to our practice. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations.

The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging we provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before your session. You and your provider can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between you, ATAGF, and your provider.

YOUR PROVIDER

Your provider is a Licensed Psychologist, Psychology Resident, or a Licensed Professional Clinical Counselor (LPCC). Individuals who are Licensed Psychologists have a Ph.D. in Clinical or Counseling Psychology and have completed the requirements for licensure as a psychologist in the state of North Dakota. Individuals who are Psychology Residents have a Ph.D. in Clinical or Counseling Psychology and are working toward completing the requirements for licensure as a psychologist in the State of North Dakota. Psychology Residents are supervised by a Licensed Psychologist in our practice and will provide you with the name of his or her supervisor during the initial session. Individuals who are LPCCs have a Master's degree in Counseling Psychology and have completed the requirements for licensure as a counselor in the state of North Dakota.

PSYCHOLOGICAL SERVICES

You are likely coming to ATAGF for psychotherapy, psychological testing, or both. Psychotherapy is not easily described in general statements. It varies depending on the personalities of the provider and patient and the particular problems you are experiencing. There are many different methods we may use to deal with the problems you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things you and your provider talk about both during your sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Yet, there are no guarantees of what you will experience.

The first few sessions with your provider will involve an evaluation of your needs. Part of this evaluation may involve completing psychological testing with your psychologist/psychology resident or with a psychology technician. By the end of the evaluation, your provider will be able to offer you some first impressions of what your work together will include. There may also be a treatment plan to follow which may include referrals to other providers for services (such as psychotherapy and/or other treatment recommendations). You should evaluate this information along with your own opinions of whether you feel comfortable working with these providers. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the provider you select. If you have questions about our procedures at ATAGF, you should discuss them with your provider whenever they arise. If your doubts persist, your provider will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

Our providers normally conduct an evaluation during the first session that typically consists of answering questions. During this time, you and the provider can both decide if he/she is the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, your provider will usually schedule one 45-minute session (one appointment hour of 45 minutes duration) per week at a time you agree on, although some sessions may be shorter / longer or more / less frequent. If you are coming for psychological testing, this testing is likely to be conducted in several different sessions. Your provider will be able to discuss his/her plan for testing with you after the initial session.

Once an appointment hour is scheduled, you are asked to provide 24 hours [1 day] advance notice of cancellation if you are unable to make it to your appointment. Although ATAGF provides reminder calls for appointment times as a courtesy, it is your responsibility to know when you are scheduled to meet with your provider. Given reminder calls are made less than 24 hours in advance, if you cancel when you get your reminder call, it is likely that your cancellation will be considered a late cancellation/no-show. After two late cancellations and/or no-shows, ATAGF providers reserve the right to remove you from a regular spot in their schedules and speak with you prior to scheduling additional appointments to determine your commitment to therapy.

PROFESSIONAL FEES

The fees involved for services at ATAGF depend upon the particular service and type of provider involved. Please contact ATAGF administrative staff or speak with your provider for more information about fees for the services provided to you. In addition to weekly appointments, ATAGF providers may charge for other professional services you may need, although the provider will break down the hourly cost if he/she works for periods of less than one hour. Other services may include but are not limited to telephone conversations lasting longer than 5 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of your provider. If you become involved in legal proceedings that require your provider's participation, you will be expected to pay for all of your provider's professional time, including preparation and transportation costs, even if your provider is called to testify by another party. Because of the difficulty of legal involvement, ATAGF providers charge more than the hourly rate for preparation and attendance at any legal proceeding. You are encouraged to discuss this fee with your providers prior to any legal involvement.

CONTACTING YOUR PROVIDER

Due to the work schedules of our providers, they are often not immediately available by telephone. Although ATAGF providers are usually in the office between 8 AM and 5 PM these hours vary based upon the individual provider with whom you are working. Please discuss office hours of your provider with him/her. Your provider probably will not be available when he/she is with a patient. The telephone is answered by an administrative assistant 8am to 8pm Monday through Thursday and from 8am to 5pm on Friday. These administrative assistants know where to reach your provider and may inform you when he or she is available to speak with you.

Your provider will make every effort to return your call on the same day you make it, with the exception of evenings, weekends, and holidays. If you are difficult to reach, please inform ATAGF administrative assistants of some times when you will be available. If you are unable to reach your provider and feel that you cannot wait for him/her to return your call, it is advised you call 911, go to your local Emergency Room, or call the 24-hour crisis line at Northeast Human Service Center at (701) 775-0525. If your provider will be unavailable for an extended time, he/she will provide you with the name of a colleague to contact, if necessary. PLEASE NOTE: **ATAGF providers do not carry a pager and are not available 24 hours a day. If you believe you may need such crisis services, ATAGF may not be the best practice for you.**

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a provider. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- Your provider may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, he/she makes every effort to avoid revealing the identity of the patient. The other professionals are also legally bound to keep the information confidential. If you don't object, your provider will not tell you about these consultations unless he/she feels it is important to your work together. Your provider will note consultations in your Clinical Record (which is called "PHI" in our Notice of Privacy Practices attached to this Agreement).

- You should be aware ATAGF providers practice with other mental health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- We also have contracts with various entities that enable us to perform treatment, billing, and practice management operations. As required by HIPAA, we have formal business associate contracts with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and/or a blank copy of this contract.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

- If a patient threatens to seriously harm himself/herself or someone else, your provider or ATAGF staff may take actions to prevent this, including seeking hospitalization for him/her, notifying law enforcement, or contacting family members or others who can help provide protection.

There are some situations where ATAGF is permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis and treatment, such information is protected by the provider-patient privilege law. ATAGF providers cannot provide any information without your written authorization or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your provider to disclose information.

- If a government agency is requesting the information for health oversight activities, your provider may be required to provide it for them.

- If a patient files a complaint or lawsuit against an employee of ATAGF, the ATAGF employee may disclose relevant information regarding that patient in order to defend him or herself.

- If a patient files a worker's compensation claim, ATAGF must, upon appropriate request, provide appropriate information including a copy of the patient's record or other information concerning mental health care services, to the North Dakota Worker's Compensation Bureau.

There are some situations in which an ATAGF provider is legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment.

- If we have reason to suspect that a child is abused or neglected, the law requires that we file a report with the Department of Human Services. Once such a report is filed, we may be required to provide additional information.

- If we have knowledge of or reasonable cause to suspect that an adult with developmental disabilities or mental illness is abused, neglected, or exploited, the law requires that we report such information to the Protection and Advocacy Project. Once such a report is filed, we may be required to provide additional information.

- If a patient threatens serious physical harm to an identifiable victim, we may take actions to protect the victim. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, your provider will make every effort to fully discuss it with you before taking any action and will limit my disclosure to what is necessary.

Although this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important you and your provider discuss any questions or concerns you may have now or in the future. The laws governing confidentiality can be complex, and your provider is not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of your provider's profession require that he/she keep Protected Health Information about you in your Clinical Record. You may examine and/or receive a copy of your Clinical Record (or a summary or explanation of the information contained in your Clinical Record if agreed by you in advance), if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, ATAGF recommends that you initially review them in your provider's presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, ATAGF is allowed to charge a copying fee of $20 per page for the first 25 pages, 75 cents per page for any pages beyond twenty-five and includes administrative, document retrieval, and postage charges. There may be instances in which your provider does not believe reviewing your record is in your best interest, and this will be discussed with you should this occur.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that ATAGF amends your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about ATAGF policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and ATAGF privacy policies and procedures. Your provider or an ATAGF administrative assistant is happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their guardians should be aware the law may allow guardians to examine their child's treatment records unless your provider decides that such access is likely to injure the child or the legal guardian and the child's provider agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes ATAGF's policy to request an agreement from guardians that they consent to give up their access to the child's records. If they agree, during treatment, the provider will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. The provider may also provide guardians with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless the provider feels the child is in danger or is a danger to someone else, in which case, the provider will notify the guardians of his/her concern. Before giving guardians any information, the provider will discuss the matter with the child, if possible, and do his/her best to handle any objections the child may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless you and your provider agree otherwise or unless you have insurance coverage that requires another arrangement. Credit card payments and similar arrangements are more confidential than checks (with names on them), as we deposit these checks into our banking account. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship,

your provider may be willing to negotiate a fee adjustment (if allowed by managed care contracts) or payment installment plan.

If you would like someone other than yourself to pay your bill at ATAGF (such as parent of someone over the age of 18), we need additional information from you. We ask you provide contact information for the individual responsible for the account and provide your written authorization for us to speak with this individual about matters pertaining to your bill. Additional information is included in the form Payment of Outstanding Balances attached to this Agreement (page 8).

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, ATAGF has the option of using legal means to secure the payment. This may involve hiring a collection agency (i.e., United Accounts) or going through small claims court which will require your provider to disclose otherwise confidential information. In most collection situations, the only information ATAGF releases regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon or if the arrangements have not been followed, your individual provider may speak with you about a referral to another agency or individual provider who is able to provide more cost-effective services to you.

INSURANCE REIMBURSEMENT

In order for you and your provider to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. ATAGF administrative assistants and your provider will fill out forms and provide you with whatever assistance he/she can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of your provider's fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, ATAGF administrative staff will provide you with whatever information they can based on their experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, ATAGF administrative staff will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. Although much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed care plans will not allow providers to provide services to you once your benefits end. If this is the case, your provider will do his/her best to find another provider who will help you continue your psychotherapy.

You should also be aware that your contract with your health insurance company requires that ATAGF provides it with information relevant to the services that your provider provides to you. Your provider is required to provide a clinical diagnosis. Sometimes your provider is required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, your provider will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Although all insurance companies claim to keep such information confidential, ATAGF has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. Your provider will provide you with a copy of any report he/she submits, if you request it in writing. By signing this Agreement, you agree that ATAGF can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, you and your provider will discuss what you can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end

your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by contract.

YOUR SIGNATURE BELOW INDICATES YOU HAVE READ THE INFORMATION IN THE PATIENT SERVICES AGREEMENT (Revised July 2014) AND AGREE TO ABIDE BY ITS TERMS DURING THE PROFESSIONAL RELATIONSHIP YOU HAVE WITH ATAGF, ITS STAFF, AND ITS PROVIDERS. YOUR SIGNATURE ALSO INDICATES YOU WERE OFFERED A COPY OF THIS AGREEMENT FOR YOUR OWN RECORDS.

_____
Printed legal name of patient

_____
Printed legal name of guardian (or "self" if the same as name of patient)

_____ _____
Signature of patient or legal guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NPP)

I acknowledge I was provided a copy of the Notice of Privacy Practices (NPP) for Assessment and Therapy Associates of Grand Forks, PLLC (effective date September 23, 2013).

Patient Name (printed): _____

Patient or Legal Guardian Signature: _____ Date: _____

*If person signing this acknowledgement is not the patient, please print your name and relationship to the patient below:

Name: _____

Relationship to the Patient: _____

For Office Use Only:

If no acknowledgement could be obtained, please document the reason(s) why below and efforts taken to obtain the acknowledgement:

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION TO INSURANCE COMPANY AND ASSIGNMENT OF BENEFITS

I hereby authorize Assessment and Therapy Associates of Grand Forks, PLLC to disclose to my current insurance carrier past and present information that is necessary to prepare an insurance claim. The insurance company will use this information to process my claim for benefits. I authorize all insurance payable on claims originating from Assessment and Therapy Associates of Grand Forks, PLLC to be paid directly to Assessment and Therapy Associates of Grand Forks, PLLC.

I understand that no other use will be made of this information except for that otherwise authorized by law.

_____	_____
Patient name (please print)	Patient/legal guardian signature Date
_____	_____
Primary policy carrier name	Name of insurance company and policy number
_____	_____
Address of insurance company	Phone number of insurance company

PAYMENT OF OUTSTANDING BALANCES

Please provide information regarding where you would like your bill sent:

Name of individual:

Address of individual:

Telephone number of individual:

If the individual responsible for paying the bill is someone other than you please complete the section below. This allows ATAGF staff to communicate with the individual paying the bill regarding matters that pertain only to bill payment. We will not communicate with this individual about other matters regarding your care unless you authorize us to do so.

I authorize Assessment and Therapy Associates of Grand Forks, PLLC (ATAGF) to communicate with _____ (print name of individual) regarding matters related to payment of my bill. I understand this may involve providing this individual with an invoice that includes dates services were provided.

_____	_____
Patient signature	Date

_____
Patient name (printed)

It is your responsibility to update this information if it changes, and you are welcome to change this information yourself at any time. If you have any questions, please contact our billing manager.

Assessment and Therapy Associates of Grand Forks, PLLC
Notice of Privacy Practices (Brief Version)

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.

Our commitment to your privacy
Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to our privacy officer (see the end of this form) about any questions or problems.

How we use and disclose your protected health information with your consent
We will use the information we collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations** (e.g., billing for services). After you have read this notice we will ask you to sign a **consent form** to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent: There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices (please ask for a copy).

Your rights regarding your health information
1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our privacy officer to arrange how to see your records. See below.
4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting area, and you can always get a copy of it from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.
7. You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for our services.
8. You have a right to be notified if there is a breach involving your PHI, if your PHI has not been encrypted to government standards; and our risk assessment fails to determine there is a low probability your PHI has been compromised.
9. You have the right to decide you would not like to be included in fundraising communications that we may send out.

Your choices regarding your health information: You also have some choices regarding whether or not we share your information. For example, whether or not we tell family or friends about your health care, releasing Psychotherapy Notes, or whether or not you are contacted for fundraising efforts. Please see the long version of our Notice of Privacy Practice for additional information.

Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies, please contact our privacy officer, who is Erin Haugen, PhD. and can be reached by phone at (701) 780-6821. The effective date of this notice is September 23, 2013.