Healthcare Management Services

3205 Randall Parkway Suite 105

Wilmington, NC 28403

Today's Date: ____________________

Identifying Information:

Patient Name: ____ **DOB:** _____/______/_____

Gender *(circle)*: Male Female **Marital Status** *(circle)*: Married Widow Divorced Single **SSN:** ____/_____/______

Address: _______________________________________**City**: ___________________**State**: _______**Zip**: _____________

Mobile Phone: ____________________________ May we leave a message at this number? Y or N

Home Phone: _____________________________ May we leave a message at this number? Y or N

Email Address: ____

Employer: ________________________________ **Occupation:** ____

Referred by: ____

Reason for Referral: ____

Insurance Information: (Please have card(s) available for photocopy)

Primary Insurance: _______________________________________ **Subscriber #:** _______________________________

Policy Holder *(if not patient)*:_______________________________ **DOB**: _____/______/_____ **Relation**: _____________

Secondary Insurance: ____________________________ **Subscriber #:** _______________________

Policy Holder *(if not patient)*:_______________________________ **DOB**: _____/______/_____ **Relation**: _____________

Financially Responsible Party *(if different than patient)*:

Name: ________________________________ **Relation**: ________________________ **Phone**: _____________________

Address: _______________________________________**City**: ___________________**State**: _______ **Zip**:_____________

Emergency Contact(s):

Name: __________________________________ **Relation**: ________________ **Phone**: ___________________________

Name: __________________________________ **Relation**: ________________ **Phone**: ___________________________

Please briefly describe the reason(s) for seeking services:

____

____

When did this problem begin? ____

Have you ever had previous counseling, psychotherapy or psychiatric services? Yes -or- No ***If yes, by whom and when?*** ____

Reason for treatment: ____

Have you ever been psychiatrically hospitalized? Yes -or- No. If yes, when and where? __________________

____

Have you ever made a suicide attempt/gesture? Yes -or- No. If yes, please explain: ____________________

____

Medications:

Are you currently taking any psychotropic medications (e.g. antidepressant, anti-anxiety, mood stimulate, etc.), indicate drug, dose, frequency?

____

____

Who prescribes the above medication? ____

Please list any other medications you take (drug, dose, frequency and prescriber): ____________________

____

____

____

Medication Allergies: ____

____

Name of Pharmacy: ______________________________ **Location/Address:** __________________________

____ **Phone**: ___________________________________

Medical Information:

Primary Care Physician: ____ **Phone**: _________________

Address: ________________________________**City**: _______________**State**: ______ **Zip**:__________

Please list any current medical conditions: ____

____

____

Past Surgical History: ____

____

Do you smoke? Yes -or- No. If yes, how often ____

Do you drink alcohol/beer? Yes -or- No. **If yes, □ less than 2x per week □ 1-2 daily □ more than 2 daily**

Have you ever had a substance abuse problem (including alcohol)? Yes -or- No. If yes, please explain _____________

____

Consent to Disclosure of PHI to Family Members, Relatives, Friends or Others

Patient Name: ____ **DOB:** _____/______/_____

I understand that, if I am present, LifeSource may disclose my PHI to other family members, relatives or friends if I orally agree or do not object.

I also understand that, if I am no present or am incapacitated, LifeSource may make limited disclosure of my PHI to other family members, relatives, or friends if LifeSource determines in its professional judgment that such disclosure is in my best interest.

I agree that LifeSource may disclose my PHI to the following family members, relatives, friends or others:

Name	Relationship	Phone Number

Patient/Legal Guardian Signature: ____ **Date:** _________________________

Authorization for Emergency Services

Should an injury or illness occur during my appointment with a LifeSource provider, I grant my authorization and consent for the provider to administer or seek a qualified person to administer general first aid treatment for any minor injuries or illnesses. If the injury or illness is life-threatening or in need of emergency treatment, I authorize the LifeSource provider to summon any and all professional emergency personnel to attend, transport, and treat me.

I agree to assume financial responsibility for all expenses of such care.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the LifeSource provider in the exercise of his or her best judgement.

This authorization is effective from the date this consent is signed until such time as services with LifeSource are discontinued.

REQUIRED SIGNATURES:

____________________________________ ____
Patient or Legal Guardian Signature POA Signature (if applicable)

____________________________________ ____
Patient or Legal Guardian Printed Name POA Printed Name (if applicable)

____
Date

List Preferred Emergency Contacts Below, if applicable:

Name(s): __________________________________ ____

Phone: __________________________________ ____

Relationship(s): ____________________________ ____

Healthcare Management Services

Please take a moment to review our general approach to treatment, our patient agreement, and our office policies.

Treatment

LifeSource utilizes a team-based approach to caring for patients.

Psychiatrists, Nurse Practitioners and Physician Assistants:

Our psychiatry providers primarily deliver treatment through the prescription and management of psychiatric medications. Our Nurse Practitioners and Physician Assistants work under the supervision of their collaborating psychiatrist to assess, diagnosis and treat patients of all ages for behavioral and mental health disorders.

Psychologists/ Psychotherapists:

Testing:

- Our therapy providers evaluate and diagnose patients using a series of behavioral health assessments.
- We offer cognitive, memory and neuropsychological testing, evaluations for ADHD and learning disorders, as well as brief cognitive behavioral therapy (CBT).

Treatment:

- Our therapists clinically assess and treat patients of all ages for a range of behavioral health issues, including depression, anxiety, ADHD, family and marital issues, school problems, PTSD and stress management.

Patient Agreement

Psychiatry Services: Psychiatry calls for compliance by you, the patient. In order for psychiatry to be most successful, you will have to take your medications as prescribed and may have to work on goals that are discussed during our sessions. You may also be asked to seek psychotherapy services to coincide with taking the medications that are prescribed. If you have questions about the medication regime that we develop, please discuss them before problems arise for you. If you are experiencing any adverse reactions to any of your medications, please let us know immediately. If your reaction is severe or life-threatening, please contact 911 or go to the closest emergency room. We are also happy to provider referrals to other professionals in the community, if needed.

Appointments: During the initial session, we will go through your medical, social and life history. It is helpful for you to bring from your pharmacy a list of all the medications you are currently taking. Even better, session notes from your previous provider are very helpful. We will determine together the medication regime

that you should be on (or continue with). You will be expected to attend follow-up sessions, generally 15-20 minutes, at a frequency determined by the treating provider. If you are late, the time will be sacrificed, as other patients are scheduled for time slots after your session. To avoid being charged for a session you cannot attend, you must call 24 hours before the allotted time, otherwise you will be charged a missed appointment fee (see Financial Policy, attached). You may leave a message on the office answering machine, knowing it is protected for your privacy.

Psychotherapy Services: Psychotherapy calls for a very active effort on your part. In order for therapy to be most successful, you may have to work on goals that are discussed during our sessions. This work together can have risks since therapy involves discussing unpleasant aspects of your life. You may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. Alternately, psychotherapy has many benefits such as solutions to specific problems, reductions in stress/distress and can contribute to improvement of relationships. If you have questions about procedures, please discuss them before problems arise for you. We are always happy to provider referrals to other professionals in the community if you or we discover we are not a good fit.

Appointments: During the first few sessions, we will determine what your goals for therapy are and the approach to treatment that is most effective. Sessions last 50 minutes and if you are late, the time will be sacrificed, as other patients are scheduled for time slots after your session. To avoid being charged for a session you cannot attend, you must call 24 hours before the allotted time, otherwise you will be charged a missed appointment fee (see Financial Policy). You may leave a message on the office answering machine, knowing it is protected for your privacy.

General Patient Responsibilities:

- ✓ To provide to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, allergies, and other matters relating to your health.
- ✓ To report unexpected changes in your condition to your provider(s).
- ✓ To make informed decisions regarding your health care including communicating that you understand the course of treatment.
- ✓ To follow the treatment plan recommended by the provider.
- ✓ To keep follow-up appointments, and when unable to do so for any reason, notify the office.
- ✓ To accept the consequences if you refuse treatment or do not follow the provider’s instructions.
- ✓ To ensure that the financial obligations of your health care are fulfilled as promptly as possible.
- ✓ To be considerate of the rights of other patients
- ✓ To respect the property of other persons and the facility.

LifeSource Office Policies

Right to Consent and Treatment: You, as the patient/ guardian, have the right to consent to or refuse treatment. You also have the right to treatment, including access to medical care and habilitation, regardless of age or degree of MH/ IDD/ SA disability.

Confidentiality: All employees and practitioners who serve you in this office respect your confidentiality. We go to extreme measures to protect your privacy, knowing that the law supports all communications between patient and professional and their agency. In most situations, your signature must be provided for an exchange of information about you and must meet the requirements of HIPPA. We hope you will maintain the same respect if you encounter a person you may recognize while in the waiting room or building. Please see the attached "Notice of Privacy Practices".

Minors, Parents and Confidentiality: Children of any age have the right to independently consent to receive mental health treatment without parental consent and IN THAT SITUATION, information about that treatment cannot be disclosed to the parent or guardian with the minor's consent. Some parental involvement is essential for successful treatment and this requires that some private information be shared with parents. For minors, we ask the patient to give oral or written permission to discuss general information with their parent(s) about the progress, attendance and billing for example. Any other communication requires written permission UNLESS THE PATIENT IS A DANGER TO SELF AND/OR OTHERS. Drug use does not necessarily constitute danger to self as it is relative to the type, amount and circumstances of use. This is further explained in the attached "Notice of Privacy Practices".

Insurance Companies and Confidentiality: We are required by your insurance company to provide them with information relevant to you, such as how we are delivering services, your attendance, a clinical diagnosis, medications and more. We do not know, nor are we able to protect this information, once it leaves our office and is given to them. This transfer of information is authorized by you when you elect to have them pay for your services. It can be avoided if you wish to pay the self-pay fee (see fee schedule). Upon your request, we will supply you with a copy of any reports we submit.

Insurance information: We recommend that you call your insurance carrier to verify your mental health benefits, co-pays and deductibles, as these can vary from other medical/ specialist benefits. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you are fully responsible for fees and not your insurance company. There are some mental health charges that insurance companies do not all reimburse for, such as custody evaluations, certain tests, or sessions beyond a specific number. We consider it your responsibility to know this in advance. It is the responsibility of the patient/ guardian to understand your insurance benefits, as well as to inform us of any changes in your insurance coverage or personal demographic information, as this information is required when filing your insurance claims.

Co-Pay and Deductibles: Co-pays, co-insurance and deductibles are due and expected at the time of service before being seen. Deductibles and co-insurance are the responsibility of the patient and are normally in addition to the co-pay. Balances remaining after 60 days from date of service must be paid by the patient until all account issues are resolved.

Missed Appointment Charge: A fee will be billed to the patient for failure to show for a scheduled appointment, or for cancellation with a 24-hour business notice. See the attached "Financial Policy".

<u>Termination</u>: Treatment may be terminated after two no-shows for scheduled appointments, or for failure to follow up regularly for ongoing treatment as determined by the provider. Termination will be immediate for any inappropriate or illegal behavior towards staff or providers on the part of the patient or his/ her family, guardians or acquaintances.

<u>Emergency Procedures</u>: Our office hours are Monday through Friday, 8am to 5pm; our offices and providers do not provide emergent care. **If you are experiencing an emergency, you should call 911 or go immediately to your nearest emergency center.** For a crisis situation, you can also call the Access Team for an in-home or on-site evaluation. Their numbers are: Crisis Line 800-672-2903 or Crisis Station 800-914-0697.

<u>Medication Refills</u>: It is our standard practice to give patients enough medication refills to last until their next scheduled appointment. Therefore, most medication refill requests cannot be granted without an appointment to discuss the benefit and possible side effects of the medications prescribed. Before notifying our office that a refill is needed, please be sure to first check with your pharmacist. Medication refills will only be processed if you've been seen by a prescriber in the last 3 months, unless otherwise noted by the provider. Once you have notified our office that a refill is needed, we will confirm a follow up appointment has been scheduled and then notify the provider of the refill needed. Refills that are approved will be processed within 48 business hours from the time we are notified.

<u>Returned Checks</u>: A $20 processing fee will be charged for all returned checks. After a returned check, the patient/ guardian may be required thereafter to pay only by cash or credit/ debit card.

<u>Documentation Preparation Fee</u>: Within reason, we will make every effort to fill out school or work notes, write letters of support, or prepare other reports as requested by patients, at the discretion of the provider. Fees may apply for this; the provider will discuss this with the patient/ guardian in advance to provide an estimate of the costs involved.

<u>Legal Proceedings</u>: Legal proceedings, letters for your insurance company, or letters to an agency that requires a signature and time to construct will be charged to you personally, unless your insurance company indicates they will reimburse for this time. Please see fee schedule for our updated rates. Legal proceedings will be charged at $250 per hour for attendance at any proceeding, including meeting with your legal representative or mediator. Psychological evaluations that require a written report for an outside agency are individualized and will be discussed with you to estimate the costs involved.

<u>HIPAA/ Privacy Notice</u>: I, the patient or guardian, understand that the HIPAA/ Privacy Notice is clearly posted in the offices at LifeSource, that I may view at any time. A copy of the Notice of Privacy Practices, as well as a Patient's Rights and Grievance Policy have been given to me, regarding the privacy and protection of my treatment at LifeSource. I understand that my treatment records are the property of LifeSource, and I have been notified that release/ disclosure of information may only occur with a consent unless it is an emergency or for other exceptions as detailed in the General Statutes or 45 CFR 164.512 of HIPAA.

Your signature below indicates that you have read the information provided in the Patient Agreement, as well as received and read our Notice of Privacy Practices and Patient Rights/ Grievance Policies and agree to abide by their terms during our professional relationship. Please obtain a copy of this document for your records.

______________________________ ______________________

Patient Signature **Date**

______________________________ ______________________

Guardian's Signature **Date**

Financial Policy

Basic Fee Schedule

	No Show Fee	Self-Pay: Initial Visit	Self-Pay: Follow-Up Visit
Psychiatry Services	$25.00	$140.00	$89.00
Psychotherapy Services	$80.00	$130.00	$79.00

OTHER FEES

Psychological Testing:
Medicare allowable rate,
see staff for details

Returned Check: $20.00

Legal Proceedings: $250/hr

Missed Appointments

LifeSource, Inc. takes great pride in the services we provide to our clients. Our providers set aside specific appointment times scheduled by you; LifeSource, Inc. does not overbook or double-book appointments. If you fail to make your appointment for any reason, general office costs continue and your doctor is unable to see other patients wishing to be seen, because your appointment time was scheduled exclusively for you. By scheduling an appointment, you are contracted for a particular block of time, whether or not you are able to keep your appointment.

If you fail to keep your appointment or have to cancel your appointment with less than a 24 business hour cancellation notice, regardless of cause, you should understand that you are fully responsible for the no-show fee* and the credit information stored on file will be charged. You will receive no further notice before this fee is added to your account. **See Basic Fee Schedule*

NOTE: Remember, 24-hour prior cancellation notice refers to a 24 "business hour" cancellation. If you have an appointment at 9 a.m. Monday morning, you are required to call our office before 9 a.m. the preceding Friday to avoid the late cancellation charge.

We do take into account missed appointments due to an emergency situation on a case-by-case basis. Repeated no-shows may be cause for dismissal from our practice.

I understand and accept the policy of LifeSource, Inc. pertaining to "No Show" appointments and appointments I have cancelled less than 24-business hours prior to my appointment. I understand and accept that I have contracted for my provider’s time, and I accept that I am fully responsible for the no-show fee listed above should this occur.

Patient Name (Print): ____

Patient Signature: ____ Date: _____ / _____ / _____

This statement of obligation extends to any person signing this form as the guardian or responsible party of the patient, whether the appointment was scheduled by the client or the responsible party.

Your financial information is kept confidential and secure, and LifeSource adheres to all federal security and identity protection standards.

LifeSource, Inc.
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: 05/01/2010 Revised Date: 09/04/2014

Definitions and Terms:

PHI – "Protected Health Information"; **refers** to identifying information in your health records.
Treatment – refers to LifeSource's management and coordination of your health care and health care related services, which is included, but not limited to consultation with other health care providers, such as your primary physician or another psychologist.
Payment – refers to reimbursement obtained by LifeSource for your health care, which requires disclosure of PHI to a health insurance company to determine coverage eligibility.
Health Care Operations – are activities that relate to the performance and operation of LifeSource's practices. Some examples are quality assessment and improvement activities, business audits, administrative services, and case management.
Use – applies only to activities within a particular practice, such as billing, medical records management, and care coordination.
Disclosure – applies to activities that reach beyond a particular practice, such as releasing or providing access to otherwise confidential information about you to other parties (e.g. insurance providers, outside referrals).

I. WE ARE REQUIRED BY LAW TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION (PHI), AND GIVE YOU NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES:

- We must protect PHI regarding: any PHI we have created or received about your past, present or future health conditions; health care services provided to you; or payment for that care to include protection of substance abuse and HIV/AIDS information.
- We must notify you about HOW we protect PHI about you.
- We must explain HOW, WHEN, and WHY we use and/or disclose your PHI.
- We will provide you a copy of this Notice prior to or when you become a LifeSource patient.
- We may only use and/or disclose PHI as we have described in this Notice.
- We reserve the right to change the terms of this Notice and to make new notice provisions for all PHI we maintain. Any changes will apply to all PHI.
    - Any updated Notices will be posted on our website: www.lifesourceinc.org and by request, will be mailed to you.
- If there is an unauthorized or improper use or disclosure of your protected health information, we are required by law to notify you.

II. WE MAY USE AND DISCLOSE PHI ABOUT YOU WITHOUT YOUR AUTHORIZATION FOR THE FOLLOWING PURPOSES:

There are certain times when we may use or disclose your PHI. When we disclose your PHI, we will comply with any and all requirements surrounding the disclosures, including, but not limited to, those found in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information and Technology for Economic and Clinical Health Act ("HITECH"), 42 C.F.R. Part 2, and North Carolina General Statutes Chapter 122c.
We are required to disclose health information about you, under certain circumstances:

1. To you, or your authorized representative, upon request.
2. To the Secretary of the Department of Health and Human Services, upon request, to determine if we are complying with the Privacy Rule

III. HOW WE MAY USE AND DISCLOSE YOUR PHI:

a. We may use and disclose PHI about you to provide health care treatment to you, (e.g. in referrals to other LifeSource-contracted clinicians).
b. We may use and disclose PHI about you to obtain payment for services (e.g. to other billing departments, insurance agencies, and collection departments).
c. We may use and disclose your PHI for health care operations, (e.g. quality improvement assessments, LifeSource business improvement evaluations, LifeSource business management and administrative activities, grievance policy resolutions, and in compliance with applicable laws and the terms contained herein.

To the extent that any of your PHI includes records covered under 42 C. F. R. Part 2, we will comply with the terms of those regulations regarding disclosure for treatment, payment, and healthcare operations purposes.

IV. WE MAY USE AND DISCLOSE PHI ABOUT YOU WITHOUT YOUR AUTHORIZATION UNDER THESE ADDITIONAL CIRCUMSTANCES:

State and Federal laws require or allow that we share your health information with others in specific situations without your consent. Prior to disclosing, we will evaluate each request to ensure that only the minimum necessary information will be disclosed, as well as ensure any required circumstances for disclosure are met.

Abuse/Neglect/Domestic Violence: LifeSource, its representatives, and contracted clinicians have a legal and ethical duty to report any such information to the Department of Social Services (DSS) and to release any such information from your records relevant to any investigation conducted by DSS.

Health Oversight: The North Carolina Psychology and Medical Boards have the authority, when necessary; to subpoena records in the event that a LifeSource contracted clinician should be the subject of an inquiry.

Judicial or Administrative Proceedings (including criminal and civil proceedings): If you are involved in a court proceeding and a request is made for your records or for information about services provided to you through LifeSource, this information is considered "privileged" under state law and may not be released without your written consent. However, this privilege does not apply when you are being evaluated for a third party or when the evaluation has been court-ordered. You will be informed in advance if this applies to you.

Serious Threat to One's Health or Safety: When information is obtained by LifeSource that indicates a serious and eminent threat to the health and safety of yourself, another person, or the public; this information must be disclosed.

Worker's Compensation: If you file a worker's compensation claim, LifeSource is required by law to provide any relevant health information to your employer and to the North Carolina Industrial Commission.

Other instances where we may be required or allowed, limited to the relevant requirements of the law (for instance, as required under North Carolina General Statutes Chapter 122c):

- LifeSource may share confidential information regarding any client with any other facility or healthcare organization when necessary to coordinate appropriate and effective care, treatment or habilitation of the patient. Coordinate shall mean the provision, coordination or management of mental health, developmental disabilities and substance abuse services and other health or related services by one or more facilities and includes the referral of a patient from one facility or provider to another.
- A facility, physician, or other individual responsible for evaluation, management, supervision or treatment of patients examined or committed for outpatient treatment under the provisions of Article 5 of the General Statute (Chapter 122) may request, receive and disclose confidential information to the extent necessary to enable them to fulfill their responsibilities.
- We may exchange confidential information with a physician or other healthcare provider who is providing emergency services to you as a patient. Disclosure of the information is limited to that necessary to meet the emergency as determined by the responsible professional.

- To individuals involved in your care or involved in payment for your care, if you have consented in writing to the release of the information to a specified person. You can object to these releases by telling us that you do not wish any or all individuals involved in your care to receive this information.
- Disclosure of fact of admission or discharge to your next of kin, whenever the responsible professional determines that the disclosure is in the best interest of the patient.
- For public health activities or risks, such as to prevent or control disease, injury or disability, report death, report reactions to medications, or notify of recalls.
- To business associates: LifeSource may share your PHI with hired associates of our organization in order for them to do the job we have hired them to do; they are also required to protect your health information and keep it confidential. (e.g., transcriptionists)
- For purpose of activities related to monitoring an FDA- regulated product, to a person subject to the jurisdiction of the FDA.
- For certain law enforcement purposes, such as for the purpose of identifying or locating a suspect or fugitive; or if you are believed to be the victim of a crime.
- To a correctional institution or other law enforcement official having lawful custody of an inmate.
- To a coroner, medical examiner or funeral director, to identify a deceased person or determine a cause of death.
- For organ procurement purposes.
- For research purposes.
- If you are a member of the armed forces, we may release medical information about you as required by military command authorities; we may also use and disclose to components of the Department of Veteran Affairs medical information about you, to determine whether you are eligible for certain benefits.
- For certain Military, National Security and Intelligence activities.

V. CERTAIN USES AND DISCLOSURES WITH YOUR AUTHORIZATION

- We will not use or disclose psychotherapy notes without your written authorization, except as allowed or required by law.
- We will not market or sell your health information without your written authorization, except as allowed or required by law.
- You may revoke a written authorization provided for any of the above purposes at any time, however, the revocation will not apply to any actions we have already taken in reliance on the authorization.

ALL OTHER USES AND DISCLOSURES NOT RECORDED IN THIS NOTICE WILL REQUIRE A WRITTEN AUTHORIZATION FROM YOU OR YOUR PERSONAL REPRESENTATIVE, UNLESS ALLOWED OR REQUIRED BY LAW.

VI. YOUR PATIENT RIGHTS:

All requests to exercise your rights must be made in writing and addressed to the attention of the Privacy Office. Mail: P.O. Box 15390 Wilmington NC 28408 - or – Fax: to 888-746-1787.

Right to Request Restrictions: You have the right to request, in writing, restrictions on certain uses and disclosures of your PHI. LifeSource is not required to agree to a requested restriction; even if we agree, your restrictions may not be followed in some situations such as emergencies or when disclosure is required by law. We may accept a restriction request disclosure of information to a health plan if you pay out of pocket in full for service unless it is otherwise required by law.

Right to Receive Confidential Communications by Alternative Means and/or at Alternative Locations: You may request and receive confidential communications of PHI by other means or at other locations. Example: requesting bills be mailed to a location other than your home address.

Right to Inspect and Copy: You have the right to inspect and/or obtain a copy of your PHI for as long as that PHI is maintained in the records. LifeSource may deny or limit your access to such records if the information to be release would be injurious to the client's physical or mental well-being, as determined by the physician or, if there is none, the facility director or his designee. You may request that this decision be reviewed by requesting we send such information to a physician or psychologist of the legally responsible person's choice for review, and in this event the information shall be so provided.
Right to Amend: You have the right to request a change, or amendment of PHI for as long as the PHI is maintained in your records. LifeSource may deny your request, but will also review the details for the amendment process, upon any patient's request.
Right to an Accounting: You have the right to receive an accounting of disclosures of PHI for which you have provided consent or authorization (as described in Paragraphs II & III, contained herein).
Right to a Paper Copy: You have the right to obtain a paper copy of the notice from LifeSource upon request, even if you previously agreed to receive the notice electronically.
Right to Breach Notification: You have the right to receive notification of any breach of your PHI.
Right to Treatment: You have the right to treatment, including access to medical care and habilitation, regardless of age or degree of disability.
Right to Consent: You have the right to consent to, or refuse, treatment.

VII. COMPLAINTS

LifeSource, Inc. recognizes the importance of confidentiality, and your right to be fully informed of all regulations regarding protected health information. If you disagree with a decision made by LifeSource, regarding your access to records; you may contact the LifeSource President at (910) 395-5569. If you file a complaint we will not retaliate against you for filing a complaint. If you feel that your privacy rights have been violated you may contact the Secretary of the North Carolina Department of Health & Human Services, Mail Service Center 3015, Raleigh, North Carolina 27699, or 919-715-1294; or Disability Rights North Carolina, 2626 Glenwood Avenue, Suite 550, Raleigh, North Carolina 27608; or 877-235-4210. Provision of services will not be affected by the filing of any complaint.

This NOTICE OF PRIVACY PRACTICES has been reviewed with me.

____________________________________ ____________________

Client, Parent, or Legal Guardian **Date**

This notice was originally published and becomes effective 5/1/2010.