



SAINT SOPHIE'S  
PSYCHIATRIC CENTER

Patient Name:

Date of Birth:

Consent & Agreement to Pay and Authorization Assignment

Rev 05/2016

I, knowing that I (or \_\_\_\_\_) have a **condition requiring diagnosis and treatment, do hereby voluntarily consent** to such diagnostic procedures and care as provided by my Saint Sophie's clinician's instructions. I consent and agree generally to assessments, psychological testing, individual, group and family therapy services. My right to information about or to refuse any test or procedure is not altered by this agreement.

Treatment is provided by medical doctors and licensed clinicians. Under the direction and supervision of the psychiatrist or other licensed clinicians of my team, students, residents or interns may perform or observe some of the health care services I receive.

I consent to a photograph to be taken for accurate identification. I understand that this photograph becomes a permanent part of the patient's medical records, and is treated like other documents within the medical record.

I have been informed and am aware that security cameras are used on the premises.

I further acknowledge that no guarantees have been made to me as to the results of treatment or examination at Saint Sophie's.

In consideration of the services provided by any and all clinicians for care and treatment, including consultations rendered to \_\_\_\_\_ for a period of such care and treatment commencing on or about the \_\_\_\_ day of \_\_\_\_\_, 201\_\_, **I hereby assign and authorize payment directly to Saint Sophie's, LLC and said clinicians of any and all Medicare/insurance benefits otherwise payable to me.**

I hereby agree that Saint Sophie's and the clinicians may receipt me for any such payment and that such receipt shall be a conclusive acknowledgment by me that I have received insurance benefits from the insurance company(ies) in the sum specified in such receipt, and agree that such payment shall discharge the insurance company(ies) of any and all obligations under the policy(ies) to the extent of such payment and for that purpose. **I expressly authorize Saint Sophie's and the clinician(s) to furnish the insurance company(ies) with any information desired concerning said care and treatment.** I understand that **I am financially responsible to Saint Sophie's and the clinician(s) for charges not covered by this assignment** and further **agree to guarantee prompt payment in full of any balance.** The original copy of this agreement of this authorization shall be kept permanently in Medical Records, therefore a photocopy shall be considered as valid as the original.

\_\_\_\_\_  
Signature of Patient or if Patient is a minor or is physically incompetent, signature/relationship of closest relative or Legal guardian)

Date: \_\_\_\_\_

Staff Witness \_\_\_\_\_

\_\_\_\_\_  
Signature of Policyholder (if Patient is Policyholder)

Date: \_\_\_\_\_

Date: \_\_\_\_\_



Patient Name:

Date of Birth:

Financial Policy

Rev 08/2019

Page 1 of 2

At Saint Sophie's, we are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an important element of your care and treatment. This Financial Policy is to assist you. If you have questions, please feel free to discuss them with our Patient Financial Services Staff.

**Unless either you or your health coverage carrier has made other arrangements in advance, full payment is due at the time of service. For insured patients, this includes any co-payments, co-insurance amounts and/or deductibles.**

**YOUR INSURANCE:** If you have insurance, we will file your claim with your insurance company, as a courtesy to you. We will extend payment terms up to 60 days in order to provide you with enough time to resolve your insurance claims. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. For patients covered by more than one policy, we also file claims to the "secondary" insurance.

**As insurance carriers** tend to change frequently, it is the policyholder's responsibility to determine whether or not we are contracted providers before being seen.

**To allow for filing** of your insurance benefits, you must bring your insurance card upon admission as well as at any time your insurance coverage changes.

**Please be aware** that few insurance companies attempt to cover all medical costs. You are responsible for payment regardless of any insurance company's determination of usual and customary rates that may bear no relationship to the current standard and cost of care in this area. If there are any disputes with your insurance carrier regarding your policy guidelines and insurance payments, it is important that you be involved to ensure that you receive the full benefit due you.

**Insurance policies vary** widely in how they pay for mental health services. Often pre-authorizations are required for a specific number of visits. In some cases, an initial referral from a primary care doctor is needed. Depending on your policy, your involvement may be critical, for some steps in the process, such as obtaining an initial referral.

\_\_\_\_\_ **I understand that any appointment that is not cancelled 24 hours prior to the appointment time will have an \$80 fee that is not covered by insurance.**

\_\_\_\_\_ I Authorize Saint Sophie's to contact my primary care physician / Managed Care Network on my behalf to request a referral that may result in coverage at the "in Network" benefit level.

\_\_\_\_\_ **Authorization for release of information to Insurance Companies:** By initialing and signing below, you are authorizing Saint Sophie's to release medical information to your insurance company, including governmental payers such as Medicare, Medical Assistance and Worker's Compensation as required or permitted by law. This includes but may not be limited to confidential medical information which may include **drug/alcohol abuse, HIV status, or psychiatric treatment** as necessary for payment of claims. This may include verbal, written or faxed information.

**I understand that Chemical Dependency client's/patient's records are protected by the Federal Law (42CFR Part 2) and cannot be disclosed without this written consent unless otherwise provided in the federal regulations. My signature also means that I have read this form and / or have had it read to me and explained in a language that I can understand.**

**Your doctor, practitioner, or therapist** can explain the reasons for the different kind of charges used, such as evaluations, individual therapy, or family therapy.

**METHODS OF PAYMENT:** We accept cash, check, VISA, and MasterCard. We do not accept post-dated checks, nor will we hold checks for any length of time. Payment arrangements may be made in advance of your appointment as necessary.

**INFORMATION CHANGES:** Be sure to advise us of any address or phone number changes. We cannot be responsible for delinquent accounts due to lack of receipt of statements or other correspondence if we do not have a current or correct address or phone number on file.

**COLLECTION PROCEDURES:** Patient Account Representatives are available to help with payment arrangements from 8:00am to 4:30pm Monday thru Friday. We do have a Hardship Program available for those patients who qualify. Once made in writing, agreements are binding. Our collection procedure does not begin until 30 days after your insurance has paid their portions, 60 days if they have not. Failure to respond to communications from our office may result in termination of treatment and/or involvement of an outside collection agency. You will be responsible for any fees or interest charged in association with collection of your account.

**ASSIGNMENT OF BENEFITS:** If you have health care insurance or are entitled to benefits under any private or government health plan or policy, you agree that Saint Sophie's may bill these priors and they may make their payments directly to Saint Sophie's. Your signature on this form is your authorized signature for the filing of a claim and request for direct payment of benefits by any payer to Saint Sophie's.



**SAINT SOPHIE'S**  
PSYCHIATRIC CENTER

Patient Name:

Date of Birth:

Financial Policy

Rev 08/2019  
Page 2 of 2

I have read and understand this financial policy of Saint Sophie's and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the organization.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Account Number



**SAINT SOPHIE'S**  
PSYCHIATRIC CENTER

Patient Name:

Date of Birth:

Acknowledgement of Receipt Notice of Privacy Practices

Rev 05/2016

It is our responsibility and intent to protect the confidentiality of our patients to the fullest extent permitted by law and according to the wishes of our patients.

The Health Insurance Portability and Accountability Act of 1996, known as HIPAA, includes important practices for healthcare organizations regarding the privacy and security of patient information.

Your signature below acknowledges you have received the Notice of Privacy Practices. This notice describes how a patient's protected health information (PHI) may be used or disclosed to carry out treatment, payment, or healthcare operations and for other purposes that are permitted or required by law. The notice also details patient rights and our duties regarding their PHI.

Thank you.

Saint Sophie's

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**Patient/Guardian Signature**

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**Date**



**SAINT SOPHIE'S**  
PSYCHIATRIC CENTER

Patient Name:

Date of Birth:

Rev 08/2019

Medication History

**Medication History:**

What medications are you currently taking and adverse side effects you had? (Include ALL medications, over-the-counter medications, herbal remedies, medical marijuana)

Medication:

Adverse Effects:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

What medications have you taken in the past? (Include ALL medications, over-the-counter medications, herbal remedies, medical marijuana)

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Allergies:**

Substance/Medication:

Reaction:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



Patient Name:

Date of Birth:

Review of Systems

Rev 08/2019

**Does the patient experience any of the following? Please check all that apply:**

**General:**  Appetite Loss  Fatigue  Fever  Obesity  Weight Change

**Skin:**  Bruising  Rashes  Excessive Sweating

**HEENT:**  Headache  Visual Problems  Hearing Problems

**Neck:**  Neck Pain  Swollen Glands

**Resp:**  Asthma  Bronchitis  Coughing  Wheezing  Difficulty Breathing

**CV:**  Blood Pressure Problems  Chest Pain  Swelling of Legs  Shortness of Breath  
 History of family member dying suddenly

**GI:**  Abdominal Pain  Diarrhea  Constipation  Trouble Swallowing

**GU:**  Bedwetting  Sexual Problems  Troubles Urinating

**MS:**  Back Pain  Joint Pain  Weak Muscles

**Neuro:**  Seizures  Decreased Memory  Loss of Consciousness

**Psych:**  Anxiety  Depression  Circumscribed Interest  Attention Problems  
 Hallucinations  Hyper Focus  Panic Attacks  Suicidal Thoughts  
 Suicidal Planning

**Endo:**  Cold Intolerance  Diabetes  Excessive Thirst  Excessive Urination  
 Thyroid Problems

**Hem:**  Anemia  Easy Bleeding  Enlarged Glands

**For Female Patients:**

**Breast:**  Mass  Pain

**Menstrual:**  Bloating  Cramping  Irregularity  Pelvic Pain



**SAINT SOPHIE'S  
PSYCHIATRIC CENTER**

Patient Name:

Date of Birth:

Adult Clinic Intake

Rev 08/2019

Page 1 of 8

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

Address: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Phone: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Born Sex: Male Female

Identifies as: Male Female

Name of Person filling out form (if different than patient): \_\_\_\_\_

What brought you to seek treatment at Saint Sophie's? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did someone refer you to Saint Sophie's? If so, who:

\_\_\_\_\_  
\_\_\_\_\_

**Past Psychiatric/Chemical Dependency treatments:**

Have you seen others in the past for psychiatric or chemical dependency issues in the past? (family practitioner, inpatient or outpatient treatments, detox, etc.) If so, specify:

Name: Location: Reason: Dates:

- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_

\*Continue on the back of form if necessary



**SAINT SOPHIE'S**  
PSYCHIATRIC CENTER

Patient Name:

Date of Birth:

Rev 08/2019

Page 2 of 8

**Medical History:**

Primary doctor or clinic: \_\_\_\_\_

Date last seen: \_\_\_\_\_

**Medical Hospitalizations:**

Where:

Reason:

Date:

- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_

\*Continue on the back of form if necessary

Are you currently being treated for any medical problems?

- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_

\*Continue on the back of form if necessary



Patient Name:

Date of Birth:

Rev 08/2019

Page 3 of 8

Do you have any concerns about your current health? (pain, eating, mobility etc):

- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_

Surgeries:

Where:

Reason:

Date:

- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_

\*Continue on the back of form if necessary

Do you smoke  Yes  No. If yes, how long? \_\_\_\_\_ Amount \_\_\_\_\_

Have you ever experienced a seizure?  Yes  No      If Yes, please describe \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



Patient Name:

Date of Birth:

Rev 08/2019

Page 4 of 8

**Family Psychiatric/Chemical Dependency History:**

Are there any psychiatric or chemical dependency issues in your family?  Yes  No (parents, brothers, sisters, aunts, uncles) If so, please describe

Who:

Type of Illness:

Reason:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Social History:**

Where were you raised and by whom? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who was living in the household when you were growing up? (relationship including siblings, other relatives, friends etc):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you get in trouble as a child/adolescent? If so, please describe:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Patient Name:

Date of Birth:

Rev 08/2019

Page 5 of 8

Any legal issues in the past or present? If so, describe:

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Were you exposed to any type of abuse (sexual, physical, emotional, verbal etc)? If so, describe type, by whom, duration:

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Education background:

Years completed: \_\_\_\_\_ Degrees/certificates/diplomas obtained: \_\_\_\_\_

Did you receive any special assistance/classes in school? If so, explain:

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Marital Status:  single  married  separated  divorced

If divorced or separated, how long? \_\_\_\_\_



**SAINT SOPHIE'S**  
PSYCHIATRIC CENTER

Patient Name:

Date of Birth:

Rev 08/2019

Page 6 of 8

Any other significant relationships not resulting in marriage (describe when, how long): \_\_\_\_\_

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Current living situation (who lives in the household, relationship): \_\_\_\_\_

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Children:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

\*Continue on the back of form if necessary

Vocation/employment history:

Type of employment:

Start Date:

Duration:

Why left?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_



**SAINT SOPHIE'S**  
PSYCHIATRIC CENTER

Patient Name:

Date of Birth:

Rev 08/2019

Page 7 of 8

Describe your typical day: \_\_\_\_\_

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Do you drink alcohol? If yes, please describe: \_\_\_\_\_

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Do you use street drugs? If yes, please describe:

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If you are having difficulties, whom do you go to for support?

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Religion: \_\_\_\_\_

Are you currently active in any church?  Yes  No

How is religion in your life? Check the best answer:

Support  Stressor  Neither



Patient Name:

Date of Birth:

Rev 08/2019

Page 8 of 8

Mood Disorder Questionnaire

Please answer the questions to the best of your ability. Has there ever been a period of time when you were not your usual self and..

Table with 3 columns: Question, Y, N. Contains 10 mood-related questions.

PC-PTSD-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic.

If you have ever experienced this type of event, please answer the following:

Table with 3 columns: Question, Y, N. Contains 5 PTSD-related questions.

Please describe what happened that was especially or unusually frightening, horrible or traumatic? \_\_\_\_\_

Please list any other problems you feel are important:

- Bulleted list with two horizontal lines for each item.

Please list questions you would like answered at this appointment if possible:

- Bulleted list with two horizontal lines for each item.



**REGISTRATION**

Patient Name: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_ Sex: M  F   
Marital status: S  M  D  W

Recent Name Change: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
(Maiden Name or Previous Married Name)

Phone # (H): \_\_\_\_\_ Phone # (W): \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Names of Other Family Members Living at Home: \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Information (Nearest friend / relative to contact in an emergency, not living with you.)

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

Address: \_\_\_\_\_ Phone # (H): \_\_\_\_\_

Phone # (W): \_\_\_\_\_

**Responsible Party:** Self  Spouse  Parent  Other  ( \_\_\_\_\_ ) Birth date: \_\_\_\_\_

Name: \_\_\_\_\_ SS# \_\_\_\_\_

Address: (if different from above)

Phone # (H): \_\_\_\_\_

Phone # (W): \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

**PRIMARY INSURANCE**

Name of Insurance \_\_\_\_\_

Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_ Effective date: \_\_\_\_\_

**Policy Holder Information**

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

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

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

**SECONDARY INSURANCE**

Name of Insurance \_\_\_\_\_

Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_ Effective date: \_\_\_\_\_

**Policy Holder Information**

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

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

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



## Saint Sophie's Notice of Privacy Practices

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

### **A. OUR COMMITMENT TO YOUR PRIVACY**

Our practice is dedicated to maintaining the privacy of your **protected health information (PHI)**. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law (the Health Insurance Portability and Accountability Act of 1996 or HIPAA) to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights concerning your PHI
- Our obligation concerning the use and disclosure of your PHI

**The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.**

### **B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:**

**Privacy Officer:** 3201 33rd St Fargo, ND 58104  
Phone: 701-365-4488 Fax: 701-365-0727

### **C. Uses and Disclosures of Health Information**

**For Treatment:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other health care providers who are involved in taking care of you now or in the future.

We may also use health information about you to call you or send you a letter to remind you about an appointment, to follow up with diagnostic tests results, or to provide you with information about other treatment and care that could benefit your health.

**For payment:** We may use and disclose medical information about you so that the treatment and services you receive at the hospital may be billed and payment may be collected from you, an insurance company or a third party.

**For healthcare operations:** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. Every effort will be made to insure anonymity

### **D. Other Disclosures**

**Business Associates:** We will share your PHI with third party associates that perform various activities for the clinic. Whenever any arrangement between our clinic and a business associate involves the use of disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

**Communication with others involved with your care:** Our health professionals may, in the event you are incapacitated or in an emergency circumstance, using their judgment, disclose to a family member, or other relative, close personal friend or any other person you identify, health information directly relevant to that person's involvement in your care or payment related to your care.

**Research:** Under certain circumstances, we may use and disclose health information about you from your medical record for research purposes. All research projects, however, are subject to a special approval process designed to protect the privacy of your health information.

**Required by law:** We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such disclosures.

**Public Health Risks:** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled or withdrawn, needs repairs or replacement
- Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

**Health Oversight Activities:** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

**Legal Proceedings:** We may disclose your PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal, in certain conditions in response to a subpoena, discovery request or other lawful purpose.

**Law Enforcement:** We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person.
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

**Deceased Patients:** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

**Organ and Tissue Donation:** Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

**Research:** Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your PHI is being used only for the research and (iii) the researcher will not remove any of your PHI from our practice; or (c) the PHI sought by the researcher only relates to decedents and the researcher agrees in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the PHI of the decedents.

**Serious Threats to Health or Safety:** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent or lessen the threat.

**Military:** Our practice may disclose your PHI if you are a member of the U.S. Armed Forces, a veteran, or a member of foreign military forces for activities deemed necessary by appropriate military command authorities, including the Department of Veteran's Affairs for the purpose of your eligibility for or entitlement to certain benefits provided by law.

**National Security:** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

**Inmates:** Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you (b) for the health, safety and security of the institution, and its officers and employees and/or (c) to protect your health and safety or the health and safety of other individuals.

**Workers' Compensation:** Our practice may release your PHI for workers' compensation and similar programs to the extent necessary to comply with applicable laws.

**Required Uses and Disclosures:** Under the law, we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirement of Section 164.500 et. seq.

We will **not** use information in your records for marketing purposes.

Other uses and disclosures from your medical record will be made only with your written authorization or approval.

### **YOUR RIGHTS REGARDING YOUR PHI**

**You have the following rights regarding the PHI that we maintain about you:**

**1. Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, please use the contact information below to make an appointment to complete the form. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

**2. Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing using the contact information below. Your request must describe in a clear and concise fashion:

- (a) the information you wish restricted;
- (b) whether you are requesting to limit our practice's use, disclosure or both; and
- (c) to whom you want the limits to apply.

**3. Inspection and Copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records. However, you may not obtain psychotherapy notes or information compiled in reasonable anticipation of a civil, criminal or administrative action or proceeding. You must submit your request in writing using the contact information below in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

**4. Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by our practice.

To request an amendment, your request and reason for the request must be made in writing using the contact information below. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) was not created by our practice, unless the individual or entity that created the information is not available to amend the information.

**5. Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing using the contact information below. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date the "accounting of disclosures" is requested and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

**6. Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time by contacting us utilizing the contact information below.

**7. Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint with our practice, use the contact information below.

**8. Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: We are required to retain records of your care.

**Contact Information:**

**Privacy Officer:** 3201 33rd St S Fargo, ND 58104  
Phone: 701-365-4488 Fax: 701-365-0727