Welcome to Promethean Psychology! Our mission is to make evidence-based psychology exciting and engaging for all. Thank you for choosing us to assist you and your family.

We'll be the first to admit it, paperwork is a drag, and we've tried to make this part of the process as swift and simple as possible. The forms enclosed in this packet/email are designed to you an idea of how we run things here, and more importantly, help us get to know you a bit more. Please complete/review the attached forms and bring the completed forms with you to the first appointment. We recommend arriving a few minutes early to your first appointment to ensure that your paperwork can be reviewed and processed. If for whatever reason printing off this packet is a hassle, not a problem. Just give us a heads up that you'll be arriving a few minutes early to your first appointment and we'll have hard copies ready for you to fill out upon arrival.

We are located at **4601 Excelsior Blvd., St. Louis Park, MN 55416 in Suite 337.** If you have any questions or need assistance with completing any of the forms, please contact us at 612-875-6867.

Promethean Psychology LLC – AGREEMENT AND CONSENT TO TREAT

Please read and review the following pages for an explanation of our office policies and keep them for your reference.

Please Initial:

Financial Responsibility and Payment Policy

_____ I agree that I am responsible for payment of all charges for psychological services provided to me. I understand that providers at Promethean Psychology are out of network and are not paneled with insurance programs. Although providers will gladly provide the client with a bill for them to submit to their insurance company for potential reimbursement, Promethean Psychology does not work directly with insurance companies and cannot guarantee any reimbursement from the client's insurance company. I accept financial responsibility for the services provided to me by Promethean Psychology.

Notice of Privacy and Client Rights

_____ I have received the Promethean Psychology Notice of Privacy Practices, which describes how confidential health information about the client may be used or disclosed and how to get access to this information. I have also received a copy of the Promethean Psychology Client Rights & Responsibilities.

Consent to Treatment

_____ Promethean Psychology aims to get people excited about evidence-based psychology. One of the ways in which we do this is by working with children, adolescents, and their families to identify and use evidence-based interventions to treat such issues as depression, anxiety, problems with sleep, and behavioral problems. Treatment is highly individualized based on presenting concerns, and the goals, purpose and procedures of the proposed treatment will be discussed in depth with the recipients of that services. I, knowing that the client has a condition requiring diagnosis and treatment, do hereby voluntarily consent to such treatment by the Promethean Psychology staff, assistants, or designees as is, in their judgment, necessary. I further acknowledge that no guarantees have been made to me as to the results of treatment. I acknowledge that many factors impact the duration of services provided including but not limited to client adherence to clinical recommendations and family/parent participation. I authorize you to provide reasonable and proper care by today's standards. If applicable, I have informed my treating provider of my mental health advance directives and have provided a copy for mental health decision-making that will become part of my treatment record.

Contact by Telephone

_____ I understand that by providing my landline or mobile number(s), I give my consent for the Clinic, their agents, and their collection agents to contact me at these numbers, or at any number that is later acquired for me, and to leave live or pre-recorded messages, or voice or text messages, regarding any accounts or services. For greater efficiency, calls may be delivered by an autodialer. Providing a telephone (landline or mobile) number is not a condition of receiving services.

You may contact me by text: Yes ____ No ____ Phone number: _____
You may contact me by phone: Yes ____ No ____
You may leave a message on my phone: Yes ____ No ____

Coordination of Care

_____ I understand that in order to provide the highest level of care, Promethean Psychology may request permission to discuss relevant aspects of care with other providers serving the client. Such providers may include but are not limited to: physicians, school personnel, and previous mental health providers. When contact with other providers is requested, a separate Authorization for the Release of Information will be completed and signed for each provider. If your clinician may communicate with the client's primary care provider (physician) about today's appointment, please sign the attached Authorization for the Release of Information Primary Care Provider form and return it with this form.

Statement of Understanding

_____ Signing below indicates that I have read or have had read to me the contents of this document and have received pertinent information regarding Office Polices, Client Rights & Responsibilities, and Notice of Privacy Practices. I agree to abide by the stated terms and conditions of service provision. I agree that these provisions will remain in effect until I provide written revocation to the Clinic. If I am signing for someone other than myself, I represent that I have legal authority to do so.

_____	_____	_____
Printed Name of Client	***Signature of Client (If not a minor)***	***Date***
_____	_____	_____
Printed Name of Legal Guardian	***Signature of Legal Guardian***	***Date***

PROMETHEAN PSYCHOLOGY LLC
CLIENT INFORMATION SHEET

Client Information

Last Name: First:	MI:	Birth Date:	
Address:	City:	State:	Zip:
Home Phone: Work Phone:	Marital Status:	Gender: M☐ F☐	Is Client Currently a Student? Y☐ N☐
Primary Care Physician (PCP):	Who were you referred by:		
PCP Practice Affiliation:	Name of organization by which you were referred by:		

Person to notify in case of an emergency:

Name	Relationship	Phone

Responsible party/Legal Guardian

Last Name: First: MI:	Birth Date:		
Address:			
City: State: Zip:			
Email Address:	Relationship to Client:		

Spouse/Other Parent

Last Name: First: MI:	Birth Date:		
Address:			
City: State: Zip:			
Email Address:	Relationship to Client:		

Primary Insurance Information

Insurance Company:	
Insured's Name:	
Policy #:	Group #:

Secondary Insurance Information

Insurance Company:	
Insured's Name:	
Policy #:	Group #:

Your signature indicates that the above information is accurate. You understand that you are responsible for payment in full at the time of service. By signing below, you understand that Promethean Psychology LLC in an out of network provider and does not participate in any insurance panels. Our office will provide you with documentation to submit to your insurance company for possible reimbursement.

NAME OF RESPONSIBLE PARTY _____ SIGNATURE OF RESPONSIBLE PARTY _____ DATE

Pretreatment Questionnaire

Client name: _____ DOB:_____ Date: _____

Form completed by: _____ ☐Self ☐Parent ☐Legal Guardian

Gender: ☐ M ☐ F ☐Other; Please specify _____

Race: ☐American Indian or Alaska Native ☐Asian ☐African American ☐Caucasian

☐Native Hawaiian or Other Pacific Island ☐Other ☐Decline to answer

Ethnicity: ☐Hispanic or Latino Origin ☐Not Hispanic or Latino Origin ☐Decline to Answer ☐Unknown

Referred by: _____ ☐Physician ☐Other Healthcare Professional ☐Employer

☐Relative ☐Friend ☐Google ☐Psychology Today

☐Other: _____

What are your child's greatest strengths?

What are your child's main interests and hobbies?

Briefly describe concern(s) for which treatment is being sought:

Please rate yourself/your child on each of the areas below and whether it has been a significant problem during the last month (skip if N/A):

	Well Below Average		Average		Well Above Average	Is this a significant problem?	
Getting along with family	1◯	2◯	3◯	4◯	5◯	Yes☐	No☐
Getting along with peers outside of the the home	1◯	2◯	3◯	4◯	5◯	Yes☐	No☐
Getting along with other adults outside of the home	1◯	2◯	3◯	4◯	5◯	Yes☐	No☐
Performance at school/work	1◯	2◯	3◯	4◯	5◯	Yes☐	No☐

Please rate yourself/your child on each of the areas below and whether it has been a significant problem during the last month (skip if N/A):

	Never		Sometimes		Always	Is this a significant problem?	
Acts without thinking	1 ○	2 ○	3 ○	4 ○	5 ○	Yes ☐	No ☐
Overactive, as if driven by a motor	1 ○	2 ○	3 ○	4 ○	5 ○	Yes ☐	No ☐
Sad, unhappy, down, or depressed	1 ○	2 ○	3 ○	4 ○	5 ○	Yes ☐	No ☐
Worried, nervous, and/or anxious	1 ○	2 ○	3 ○	4 ○	5 ○	Yes ☐	No ☐
Academic difficulties at school	1 ○	2 ○	3 ○	4 ○	5 ○	Yes ☐	No ☐
Behavioral difficulties at school	1 ○	2 ○	3 ○	4 ○	5 ○	Yes ☐	No ☐
Sleeping problems	1 ○	2 ○	3 ○	4 ○	5 ○	Yes ☐	No ☐
Problems with temper, having a 'short fuse'	1 ○	2 ○	3 ○	4 ○	5 ○	Yes ☐	No ☐
Difficulty tolerating frustration/change	1 ○	2 ○	3 ○	4 ○	5 ○	Yes ☐	No ☐
Problems with peers	1 ○	2 ○	3 ○	4 ○	5 ○	Yes ☐	No ☐
Picky eater	1 ○	2 ○	3 ○	4 ○	5 ○	Yes ☐	No ☐
Other: _____	1 ○	2 ○	3 ○	4 ○	5 ○	Yes ☐	No ☐

Individuals living with you/your child:

Name_____ Age_____ Relationship_____
Name_____ Age_____ Relationship_____
Name_____ Age_____ Relationship_____
Name_____ Age_____ Relationship_____
Name_____ Age_____ Relationship_____
Name_____ Age_____ Relationship_____

Parents Divorced/Separated/Not Living Together: ☐Yes ☐No If yes, please describe current parenting schedule/custody arrangement:

Educational History:

Current school: _____ Current grade: _____

Special education placement? ☐Yes ☐No if yes, in what area? _____

Has the school performed psychological testing? ☐Yes ☐No If so, when?_____

Is there an IEP (Individual Educational Plan) or 504 plan in place? ☐Yes ☐No *If yes*: ☐IEP ☐504 plan

Previous Mental Health Treatment: ☐None ☐Yes (please describe below)

General time frame (e.g., month/year)_____

Clinician and organization_____

Reason for seeking treatment_____

Current Legal Concerns: ☐Yes ☐No If yes, please explain:

Past History of Abuse: ☐Yes ☐No If yes, please explain:

Developmental History:
Complications during pregnancy, at birth or in early childhood? ☐Yes ☐No If yes, please explain:

Medical Diagnoses and Conditions: ☐None ☐Yes_____

History of Major Surgeries and/or Hospitalizations: ☐Yes ☐No If yes, please detail below:

If applicable, please describe any other significant medical history for your child:

Allergies: ☐None ☐Other: _____

Immunizations current? ☐Yes ☐No If no, please explain below:

Medications (prescribed and over-the-counter): ☐None

Medication _____ Dosage _____ Prescribing Physician _____ Started _____
Medication _____ Dosage _____ Prescribing Physician _____ Started _____
Medication _____ Dosage _____ Prescribing Physician _____ Started _____
Medication _____ Dosage _____ Prescribing Physician _____ Started _____

Substance Use:
Alcohol use: ☐None ☐Suspected ☐Known to use currently ☐Recovering

Drug use: ☐None ☐Suspected ☐Known to use currently ☐Recovering

Type: _____ Amount: _____ How often?_____

If necessary, please provide additional information regarding alcohol and drug use history:

Additional Remarks: Please use this page to write any additional comments you wish to make regarding your child's difficulties or anything else that you feel would be helpful for the clinician to know about your child.

Authorization to Release/Request Confidential Information to Primary Care Provider

Client Name: _____ Date of Birth: _____

Name of Provider: _____

☐I do authorize Promethean Psychology LLC to contact/communicate with my child's Primary Care Provider
☐I do **NOT** authorize Promethean Psychology LLC to contact/communicate with my child's Primary Care Provider

To/From (or Primary Care Provider/Clinic)

Name: _____

Clinic: _____

Address: _____

Phone: _____ **Fax:**_____

Email _____

Address:

Release Format: ☐Paper ☐Electronic

Release Method: (Check all that apply): ☐Email ☐Mail ☐Fax ☐Pick up ☐Verbal

☐Other_____

Scope of Authorization:
The private health information and/or health records to be released include:
☐Complete Record
☐Assessment(s)
☐Test Result
☐Treatment Plan
☐Therapy Data
☐Progress Data
☐Diagnostic Impression(s)
☐Termination/Discharge Information

Purpose of Release:
The release of the designated information and/or records is the purpose(s) of:
☐Coordination of Care.
☐I do NOT want my clinician to coordinate care with another provider.
☐I authorize only an initial Coordination of Care letter to be issued to another provider.
☐I authorize the ongoing exchange of the designated information an/or records via mail, fax, email, or verbal communication to the designated recipient.
☐Transfer to another provider.
☐Other _____

By signing this authorization form, I understand that:

- I have the right to revoke this authorization at any time. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless revoked, this authorization will expire in one (1) year from the date signed or on the following date/event whichever occurs sooner. Date_____ or Event_____
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information has the potential for re-disclosure, and may not be protected by state, federal, or other confidentiality law.
- Requests for copies of records may be subject to fees in accordance with applicable law.
- If I request release by unencrypted email or another unsecure method, I have been warned and accept the security risks to the information associated with the unsecure transmission, and Promethean Psychology LLC is not responsible for breach notification or liable for disclosures that occur in transit.

Print Client Name (If a minor, person authorized to sign)	Signature of Client (If a minor, person authorized to sign for Client)	Relationship to Client	Date

OFFICE POLICY

Welcome to Promethean Psychology! Our mission is to make evidence-based psychology exciting and engaging. The information below is provided to give you an idea as to how we run things here at Promethean Psychology and ensure that you have a full understanding of our office policies. If you have any questions, please do not hesitant to contact Dr. Sam at **612-875-6867**.

OFFICE HOURS – Office hours are 9:00 a.m. to 7:00 p.m., Monday through Thursday; and 9:00 a.m. to 5:00 p.m. on Friday. We are closed on Saturdays and Sundays. Appointments outside of these hours may occasionally be available. Check with Dr. Sam for further information. To schedule an appointment, you are welcome to either contact Dr. Sam by phone at 612-875-6867 or send him a secure message through our website at prometheanpsychology.com/contact or via email at smarzouk@prometheanpsych.com.

AFTER HOURS – Dr. Sam likes to occasionally sleep and eat, so he is not always in the office. After office hours, feel free to leave a message at our main number 612-875-6867. In the case of an emergency, call 911 or go to the nearest hospital emergency room.

FINANCIAL RESPONSIBILITY AND PAYMENT POLICY – You are responsible for payment of all charges for psychological services or programming provided.

INSURANCE – Please note that we do not participate with insurance plans. We are more than happy to provide you with all necessary paperwork for you to submit to your insurance company, although full payment is due at the time of service/program delivery.

CANCELLATION – Life happens. We get it. If you need to cancel, all we ask is that you give us at least a 24-hour cancellation notice. We offer two "freebies" meaning you are allotted two free passes with no penalty should you cancel with less than a 24-hour notice. After that we reserve the right to charge the full amount for the missed appointment.

LATE APPOINTMENTS – If you are more than 15 minutes late to a scheduled appointment, we reserve the right to reschedule.

TERMINATION – Termination of services may occur when three appointments are missed without proper cancellation or when treatment recommendations are not accepted or followed.

FAMILY INVOLVEMENT – With 'science' being one of our core values, our duty is to provide the most effective, evidence-based treatment for each and every client. Oftentimes involvement of the family (e.g., legal guardians) is viewed as essential in maximizing treatment success.

CLIENT RIGHTS – Please review the client rights and responsibilities information posted in our office and on our website at www.prometheanpsychology.com

CONFIDENTIALITY – It is the Provider's policy to safeguard the privacy of the Client's health information and records to the fullest extent permitted by law. However, in some circumstances, the Provider may be required to disclose private health information and/or records of the Client to other people even if the Client has not consented to that disclosure. Examples of situations in which the Provider may have to make such disclosures include, but are not limited to:

1. If the Provider receives information from the Client or others indicating that abuse or neglect of a minor or abuse or neglect of a vulnerable adult has occurred, the Provider may have to report that information to a law enforcement agency or to other government entities;

2. If the Client or another person has communicated to the Provider a threat of violence to the Client or to some other potential victim, the Provider may have to inform the potential victim and/or a law enforcement agency of the threat;

3. If, in the Provider's judgment, disclosure to a parent or guardian of any treatment given to or needed by a minor client is necessary to prevent serious harm to the health of the minor client;

4. If the Provider is required by a court order or subpoena, the Provider may be required to disclose information to person(s) as directed by the order or subpoena;

5. If an investigation is being conducted by a licensing board or other government entity, the Provider may have to disclose information as directed by that board or entity;

6. If there is a federal or state law that requires the Provider to disclose information in other circumstances, the Provider may have to disclose the information to the extent required by that law.

That list is not exhaustive; there may be other situations in which I may have to disclose information about the services I am providing even if you do not want me to do so.

FINANCIAL POLICIES AND PROCEDURES

Thank you for choosing Promethean Psychology LLC. We are committed to making the payment process as clear and convenient as possible. As one of our clients, we want to ensure you have a clear understanding of our payment policy. Please read this carefully and do not hesitate to ask any questions that you may have.

RESPONSIBILITY FOR PAYMENT – You will be billed for the services on behalf of the person who is providing them. It is your responsibility to pay for the services according to these financial policies and procedures unless satisfactory arrangements are made for payment by another person or entity.

SCHEDULE OF FEES – The fees for our services are based on an hourly rate or rates, depending on the type of services being provided. The specific rates are stated below. They are subject to change from time to time, and we will notify you if they do change.

a. Initial Assessment/Intake lasting approximately 90 minutes: **$295**
b. Follow-up psychotherapy appointments lasting approximately 45 minutes: **$185**
c. Shorter appointments, lasting for 25 minutes: **$125**

FEE SCHEDULE FOR LEGAL PROCEEDINGS – Should a client become involved in legal proceedings that require my involvement, it is expected that you will compensate me for my time. My fee is **$450** per hour which includes preparatory work and actual time spent attending any legal proceeding.

FEE STATEMENT – Unless other arrangements are made, we will provide our fee statement directly to you for payment. The fee statements will contain the date(s) of service, the type of service provided, the name of the person providing the service, and the fee for the service. If you need additional information about fees, please let us know.

RIGHT TO RECEIVE A GOOD FAITH ESTIMATE OF EXPECTED CHARGED UNDER THE NO SUPRISES ACT – Under section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a federal health care program, or not seeking to file a claim with their plan or coverage upon request or at the time of scheduling health care services, of a "Good Faith Estimate" of expected charges. Please note that you will be provided a "good faith estimate" at the outset of therapy services which will give you an estimate of the total financial cost of therapy services. You also have the right to ask for a "good faith estimate" any time during the course of treatment.

TERMS OF PAYMENT – It is our policy to require payment for the services at the time the services are provided unless other satisfactory arrangements are made. If you want to discuss arrangements for a payment plan, please let us know. If you cannot afford services, we will provide you with a referral to another provider or other resources.

FORMS OF PAYMENT – We offer three convenient ways to pay for services. We accept cash or check at the time of service. You may also pay with your credit/debit/HSA card on our website at www.prometheanpsychology.com/payment. Additionally, we are able to keep your credit card information (HSA cards also accepted) securely on file and charge it at the conclusion of a service.

INSURANCE – Promethean Psychology is "out-of-network" for all insurance carriers. However, it is still possible that your insurance will cover some of your expenses at Promethean Psychology. We recommend that you contact your insurance carrier to determine what "out of network" benefits you have for mental health treatment and how much they will cover. We are more than happy to provide you with documentation of our services which can be submitted to your insurance carrier for possible out-of-network reimbursement.

Some questions to ask your insurance company include:

1. Does my policy provide reimbursement for out-of-network providers?
2. What percentage do you provide reimbursement for?
3. Is there a deductible I must pay before I receive such reimbursement?
4. What information do you need me to submit to you?
5. Do you require any type of preapproval or preauthorization?

Please do not hesitate to call if you have any questions about your bill or our payment policies. Calling us with questions will help prevent any misunderstandings as most problems can be cleared up quickly and easily. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Promethean Psychology LLC Client Rights & Responsibilities

Client Rights to Services

You have a right to:

- Reasonable access to services regardless of race, religion, gender, sexual orientation, or ethnicity.
- Be informed about the qualifications of the clinical staff who are responsible for client's care, treatment, and services.
- Receive services during office business hours (please see our office policies for hours of operation).
- Receive a "good faith estimate" of total financial cost of therapy services
- Receive evidence-based, individualized treatment.
- Refuse care, treatment, and services and to be informed about what will happen if this occurs.
- You also have the rights specified in Minnesota Statute 144.651.

Responsibilities of Clients

It is your responsibility to:

- Provide our office with your current contact information and notify staff of any changes.
- Keep scheduled appointments and, when necessary, cancel them at least 24 hours in advance.

Complaints or Grievances

If you have a complaint or grievance:

- You have the right to file a complaint or grievance without interference from or retaliation by us.
- To do so, you may contact the owner/director of the clinic and/or you can contact the Minnesota Board of Psychology. https://mn.gov/boards/psychology/

Promethean Psychology LLC Notice of Privacy Practices

This notice described how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully

EFFECTIVE DATE: July 20, 2019

Our Commitment Regarding your Information: At Promethean Psychology we are committed to protecting the personal information we obtain about you while providing services. We are required by law to follow the privacy practices described in this Notice. We may change our privacy practices at any time. Such revised privacy practices will be set forth in a revised Notice and will be effective for all service information that we maintain at that time. A current copy of our Notice of Privacy Practices will be posted in a visible location at all times in our office at 4601 Excelsior Blvd., Suite 337, St. Louis Park, MN 55416. In addition, this Notice will also be posted on our website: wwww.prometheanpsychology.com in the "forms" section.

Who will follow this notice: This notice describes the privacy practices of Promethean Psychology LLC (herein after referred to as Promethean Psychology) and their health care professionals. Each of the foregoing individuals and entities may use, share, and/or disclose medical, service, and other personal information with each other for the treatment, payment, or health care operations purposes described herein.

Understanding your record/information: When you begin services or programming through Promethean Psychology, a record is created. This record may include personal information about you, your physical, mental and behavioral health, treatment and diagnosis, and other information related to services rendered by Promethean Psychology (such information is collectively referred to herein as "Your Information"). Your Information may be in the form of a medical record, a client record, a combination of these or another type of written service record. Your Information may be protected by certain state and federal laws and regulations. For instance, The Health Insurance Portability and Accountability Act (HIPAA), regulates Promethean Psychology's use of protected health information. "Protected health information" is Your Information, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services and is maintained by a covered entity or the business associate of a covered entity. Promethean Psychology uses Your Information to plan your care, to provide treatment to you, and to provide other psychological services to you. Your Information is also used as a communication tool by insurance companies (when applicable) to verify that services we billed for were actually provided. Although owned by Promethean Psychology, you do have certain rights with regard to Your Information. This notice will tell you about the ways in which we may use and disclose Your Information to others. It also describes your rights and certain obligations we have regarding the use and disclosure of Your Information.

Promethean Psychology's Duties: Promethean Psychology is required by law to maintain the privacy of your protected health information, to provide you this notice of Promethean Psychology's legal duties and privacy practices with respect to protected health information, and to notify

affected individuals following a breach of unsecured protected health information. Promethean Psychology is also required to abide by the terms of this Notice currently in effect.

How We May Use and Disclose Service Information about you: The following categories describe different ways we use and disclose Your Information without your authorization. For each category of uses and disclosures, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. Many of the ways we are permitted to use and disclose information will fall within one of the identified categories.

- *For Treatment*: Your Information obtained by Promethean Psychology will be recorded in your client record and used to determine the course of your treatment and other services. We will use or disclose Your Information to provide, coordinate, and manage your healthcare services. For example, Promethean Psychology team members will communicate with one another personally and through your service record to coordinate your care. We may disclose Your Information to another entity, such as a legal guardian or placing agency, or another youth care or health care provider who becomes involved in your care.
- *For Payment*: We may use and disclose Your Information so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may tell your health plan about a treatment you are going to receive to obtain approval or to determine whether your health plan will cover the treatment. We may also disclose Your Information to another service provider for its payment purposes.
- *Notification/Communication of Your Condition*: We may use or disclose Your Information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. We will only release this information if you agree, are given the opportunity to object and do not, or if in our professional judgment, it would be in your best interest to allow the person to receive the information or act on your behalf. Unless state or federal law otherwise restricts us, or unless you instruct us not to, we may release your location within Promethean Psychology's facilities and general condition to people who ask for you by name. In addition, we may release your name, location, general condition and religious affiliation to members of the clergy.
- *As Required by Law*: We may use or disclose Your Information when required to do so by federal, state or local law.
- *Workers' Compensation*: We may release Your Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- *Public Health Activities*: We may disclose your service information to a public health authority that is permitted by law to collect or receive the information. This includes reporting child abuse, domestic violence or neglect, FDA regulated products or activities, and exposure

to communicable diseases. We may be required to report information to help prevent or control disease, injury, or disability. We may also disclose information, if directed by the public health authority, to a foreign government agency that collaborates with the public health authority.

- *Military Activity and National Security*: We may use or disclose the service information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities, (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your service information to authorized federal officials for conducting national security and intelligence activities, including providing protective services to the President of the United States or others.
- *Law Enforcement*: Under certain circumstances, we may disclose Your Information to law enforcement officials, with some examples being:
    - reporting actual or threatened mental harm or physical injuries;
    - in response to a court order, subpoena, warrant, summons or similar process;
    - to identify or locate a suspect, fugitive, material witness or missing person;
    - inquires as to the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
    - to alert authorities of a death we believe may be the result of criminal conduct;
    - information we believe is evidence of criminal conduct occurring on our premises;
    - if we believe in good faith that a disclosure of your service information is necessary to prevent or minimize a serious threat to you or the public's health or safety;
    - in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime; and
    - we may release Your Information to correctional institutions or law enforcement officials if you are an inmate of a correctional institution or under the custody of a law enforcement official.
- *Coroners, Medical Examiners and Funeral Directors***:** We may provide Your Information to a coroner or medical examiner. For example, such disclosure may be necessary to identify a person who has died or to determine the cause of death. We may also provide Your Information to funeral directors who need to carry out their duties.
- *Judicial and Administrative Proceedings*: If you are involved in a lawsuit or a dispute, we may be required to disclose service information about you in response to a court or administrative order. We may also be required to disclose service information about you in

response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if reasonable efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- *Public Health and Health Oversight Agencies*: We may disclose Your Information to health oversight agencies, public health authorities, or other government agencies that monitor the health care system, related government programs, and compliance with applicable civil rights laws.
- *Health Information Exchange*: We may participate in one or more electronic health information exchanges which permit us to exchange Your Information with other participating providers, health plans, and their business associates. For example, we may permit a health plan that insures you to electronically access Your Information to verify a claim for payment of services rendered by us. Or, we may permit a physician providing care to you to electronically access Your Information in order to have up to date information with which to treat you. Participation in a health information exchange also lets us access medical information electronically from other participating providers and health plans for our treatment, payment, and youth- and health-care care operations purposes as described in this Notice. We may in the future allow other parties, for example, public health departments that participate in the health exchange, to access Your electronically for their purposes.

Other Uses and Disclosures: Other uses and disclosures of Your Information not covered by this notice or the laws that apply to us may require your specific written authorization. If you provide us authorization to use or disclose Your Information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose Your Information for the reasons covered by your written authorization, except where permitted by law. You understand that we are unable to take back any uses or disclosures we have already made in reliance on your authorization and that we are required to retain records of care provided.

Your Rights Regarding Your Information: You have the following rights regarding your information:

- *Right to Notification in the Case of Breach*: We are required by law to notify you of a breach of your unsecured protected health information. We will provide such notification to you without unreasonable delay, but in no case later than 60 days after we discover the breach.
- *Right to Inspect and Copy*: You have the right to inspect and copy Your Information that may be used to make decisions about your care. Usually this includes service and billing records. This does not include psychotherapy records. You must submit your request to inspect and copy Your Information in writing to Promethean Psychology director, Sam Marzouk, Ph.D. Our office may charge you a reasonable fee for copying, mailing, labor and supplies

associated with your request. If we maintain Your Information electronically in one or more designated record sets and if you ask for an electronic copy, we will provide the information to you in the form and format you request, if it is readily producible. If we cannot readily produce the record in the form and format you request, we will produce it in another readable electronic form we both agree to. In addition to the costs described above, we may charge a cost-based fee for our staff to make the electronic copy. If you direct us to transmit Your Information to another person, we will do so, provided your signed, written direction clearly designates the recipient and location for delivery. All requests are subject to reasonable notice and reasonable time to produce the requested information. In addition, we may deny your request to inspect and copy Your Information in certain circumstances. If you are denied access to Your Information, you may request that the denial be reviewed. We will provide you, in writing, with our reasons for the denial of access and with instructions for having a denial of access reviewed.

- *Right to Amend*: You may request an amendment of Your Information that we maintain. Such a request must be in writing and provided to our office. In addition, you must provide a reason that supports your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement that will become part of your service information. If you file a statement of disagreement, we reserve the right to respond to your statement. You will receive a copy of any response we make and any such response will become part of your service information.
- *Right to an Accounting of Disclosures*: You have the right to request an accounting of disclosures, which is a list of certain disclosures of Your Information. Your right to an accounting does not include disclosures for treatment, payment and youth and healthcare operations and certain other types of disclosures, for example, as part of a facility directory or disclosures made with your written authorization. To request an accounting of disclosures, you must submit a request in writing to our office. Your request must state a time period that is not longer than six years and may not include dates before January 1, 2009. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list of disclosures you request within a 12-month period will be free. We may charge for the costs of providing additional lists. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.
- *Right to Request Restrictions*: You have the right to request a restriction or limitation on Your Information that we may use or disclose for treatment, payment or healthcare operations. You also have the right to request a limit on Your Information we disclose to someone who is involved in your care or the payment for care, like a family member or friend. Except as described below, we are not required to agree to your request. If we do agree to the requested restriction, we

may not use or disclose Your Information in violation of that restriction unless there is an emergency. We are required to agree to your request that we not disclose certain protected health information to your health plan for payment or health care operations purposes, if you pay out-of- pocket in full for all expenses related to that service prior to your request, and the disclosure is not otherwise required by law. Such a restriction will only apply to records that relate solely to the service for which you have paid in full. If we later receive an authorization from you dated after the date of your requested restriction which authorizes us to disclose all of Your Information to your health plan, we will assume you have withdrawn your request for restriction. To request restrictions, you must make your request to our office. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

- *Right to Request Confidential Communications*: You have the right to request that we communicate with you about Your Information in a certain way or at a certain location. Your request must be in writing, addressed to our office and must specify how or where you wish to be contacted. We will not ask you for the reason for your request. We will accommodate reasonable requests.
- *Right to a Paper Copy of this Notice*: You have the right to request a paper copy of this Notice. To obtain a paper copy of this Notice, contact our director, Sam Marzouk, Ph.D. You may obtain an electronic copy of this notice at www.prometheanpsychology.com.
- *Our Responses to Your Requests*: We will respond to your requests to exercise any of the above rights on a timely basis in accordance with our policies and as required by law.

Changes to this Notice: We reserve the right to or may be required by law to change our privacy practices, which may result in changes to this Notice. We further reserve the right to make the revised or changed Notice effective for service information we already have about you as well as any information we receive in the future. The Notice will contain the version number and effective date.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the director, Sam Marzouk, Ph.D. ***You will not be penalized or otherwise retaliated against for filing a complaint.***

Contact: If you have any questions or would like additional information about this notice or our Privacy Practices, please contact our director at the address set forth below:

Promethean Psychology, LLC
Attention: Sam Marzouk, Ph.D., L.P.;
Founder and CEO
4601 Excelsior Blvd, Suite 337
St. Louis Park, Minnesota 55416