Lifescape Medical Associates, P.C.
Confidential
Client Agreement
Lisa K. Strohman, Ph.D., J.D.

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Welcome to my practice at Lifescape Medical Associates, PC. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law (implemented in April, 2003) that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

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

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

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation "phase," I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Appointments
I normally conduct an evaluation that will last 1 or 2 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is initiated, together we will determine a schedule for 50-minute sessions (one appointment "hour" of 50 minutes duration) to address treatment. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control].

Professional Fees
My hourly fee is $225.00. In addition to therapy appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services may include report writing, telephone conversations lasting longer than 10 minutes, email correspondence, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $425 per hour for attendance at any legal proceeding. If you are interested in having access via telephone and/or email with me our office will require a credit card on file for this virtual appointment time.

Contacting Me
Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 7:30 AM and 5 PM, Monday through Friday, I do not answer the telephone when I am with a patient. When I am unavailable, my telephone is answered by an answering machine that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or call 911 for assistance.

Limits on Confidentiality

In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA and/or Arizona law. However, in the following situations, no authorization is required:

(1) I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record;

(2) Disclosures required to collect overdue fees are discussed elsewhere in this Agreement. There are some situations where I am permitted or required to disclose information without your Authorization;

(3) If you are involved in a court proceeding and a request is made for information concerning the professional services I provided, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information;

(4) If a government agency is requesting the information for health oversight activities, I may be required to provide it for them;

(5) If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself;

(6) If a patient files a worker's compensation claim, I may be required, upon appropriate request, to provide all clinical information relevant to or bearing upon the injury for which the claim was filed;

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

(1) If I have reason to believe that a child under the age of eighteen (18) years has been abused, abandoned or neglected or who observes the child being subjected to conditions or circumstances which would reasonably result in abuse, abandonment or neglect, the

law requires that I file a report with the appropriate government agency, usually Department of Health and Welfare. Once such a report is filed, I may be required to provide additional information.

(2) If a patient communicates an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such a threat, I may be required to take protective actions. These actions may include notifying the potential victim and contacting the police, and/or seeking hospitalization for the patient.

(3) If I believe that there is an imminent risk that a patient will inflict serious physical harm or death on him/herself, I may be required to take protective actions. These actions may include attempting to hospitalize the patient, calling the police or contacting family members or others who can assist in protecting the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

Professional Records

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances where I believe that access would seriously endanger you or others or the record makes reference to another person (other than a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. I am sometimes willing to conduct this review meeting without charge. In most circumstances, I am allowed to charge a copying fee of $1.00 per page (and for certain other expenses). The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your Clinical Records, you have a right of review (except for information supplied to me confidentially by others), which I will discuss with you upon request.

In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

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

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

Billing & Payment
You will be expected to pay for each session at check- in, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested. If you decide to participate in my telephone and/or email consultations our office requires a credit card on file for these virtual appointment times. In circumstances of unusual financial hardship, I may be willing to negotiate a payment installment plan.

Insurance Reimbursement
I am committed to providing my patients with the finest possible psychological care. Insurance companies often do not understand and/or disregard the therapeutic needs

involved in counseling. Rather than compromise the welfare of my patients, I have elected to not participate in the insurance payer system. I do this to create an environment where my focus is solely on the patient leaving me free to serve them with all my skill and knowledge undiminished and unbiased by arbitrary reimbursement policies.

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with an invoice of each session to help you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees.

You should also be aware that in the event you decide to bill your health insurance company, they will require that I provide them with information relevant to the services that I provide to you. Specifically, I will be required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____

Printed Name of Client Signature

_____ _____

Parent or Guardian Signature

_____

Date

CONFIDENTIAL CLIENT INTAKE INFORMATION QUESTIONNAIRE

Lisa K. Strohman, Ph.D., J.D.

8757 E. Bell Rd., Scottsdale, Arizona 85260
Telephone (480) 650-1720 Facsimile (480) 452-1705
Electronic mail –asklisa@hushmail.com

Child or Teenager's Name: _____ Age: _____ Birthdate: _____ Today's Date: _____

Address: _____ _____ _____ _____ Home phone: _____
Street or P.O. Box number City State Zip code email address:_____

Electronic mail address _____ Office or work phone: _____

Birthplace: _____ Parent's names: _____ age: _____ _____ age: _____
(or guardians) mother father

Parent's occupations: _____ Phone at work: _____ _____Phone at work: _____
(or guardians) mother Father

Names and ages of brothers and/or sisters:
_____
(please circle the names of those living at home)

Who referred you to me? _____

School: _____ Grade: _____ Religious preference: _____

Grades in school (how are you doing?) _____GPA? _____

Have you ever seen a school counselor or psychologist? ☐yes ☐no If yes, when? _____

What was the problem?
_____

Have you ever been seen by a probation officer? ☐yes ☐no If yes, why? _____

List any major health problems:
_____

List any medications you now take:
_____

Have you been in counseling before? _____ ☐yes ☐no If yes, when: _____ Counselor? _____

Problem? _____ Was counseling helpful? _____

Please check or circle any of the following which are currently troubling you:

divorce	making decisions	restlessness	sexual abuse	compulsions
jealousy	self-control	short attention span	shyness	sadness
stubbornness	lying	aggressive feelings	confidence	loneliness
uncooperative	cheating (at school)	physical fighting	anorexia	temper
headaches	feeling alienated	can't be alone	panic attacks	depression
sleep trouble	family conflict	siblings	drug use	alcohol use
guilt	weight loss	disorganized	anger	stress
appetite	weight gain	losses, sadness: death	sleep too much	concentration
friends	low self-esteem	sexual identity	nightmares	defiance
unhappiness	health problems	destructive behavior	fears	skipping school
school	sex problem	dating problems	energy level	teachers
withdrawal	suicidal feelings	can't relax	hate	teasing

_____

What do you want to get out of this counseling? Please describe in a few words.

_____

_____

_____

Thanks for your patience in filling out this form. It will help me work more effectively with you. If you have any questions about any of the items on this questionnaire, please feel free to bring them up.

This form was completed by: _____
(name of child, adolescent, or parent)

Signature _____

Please be aware that we operate on a "cash" basis. That is, we expect FULL payment at the time of each visit. If you have health insurance that covers psychological services our office will provide you with a receipt for you to file with your insurance. We currently charge $100.00 per 50 minute "hour." I generally operate very much on time so it will be to your advantage to arrive on time for your appointment. Your appointment time is reserved exclusively for you, and thus we do charge for uncancelled or missed appointments. If you have questions about financial arrangements please bring them up. Thanks!

Limits of Confidentiality

The contents of a counseling, intake, or assessment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this clinic not to release any information about a client without a signed release of information. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Court Orders

Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up

their access to their child's records. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he or she may have.

As legal guardian of the minor patient, I do / do not agree to waive my right to examine the treatment records. I will receive only general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. _____ (initials of parent guardian).

Other Provisions

When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, case notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, time frame, and the name of the clinic.

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.

In some cases notes and reports are dictated/typed within the clinic or by outside sources specializing (and held accountable) for such procedures.

When couples, groups, or families are receiving services, separate files are kept for individuals for information disclosed that is of a confidential nature. The information includes (a) testing results, (b) information given to the mental health professional not in the presence of other person(s) utilizing services, (c) information received from other sources about the client, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries, and (h) information that has been requested to be separate. The material disclosed in conjoint family or couples sessions, in which each party discloses such information in each other's presence, is kept in each file in the form of case notes.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please list where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only.

If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic

(to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

Please check where you may be reached by phone. Include phone numbers and how you would like us to identify ourselves when phoning you.

____ HOME Phone number: _____
How should we identify ourselves? _____
May we say the clinic name? _____ Yes __ No

____ WORK Phone number: _____
How should we identify ourselves? _____
May we say the clinic name? _____ Yes __ No

____ OTHER Phone number: _____
How should we identify ourselves? _____
May we say the clinic name? _____Yes __ No

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____ _____

Printed Name of Patient Signature Date

_____ _____

Parent or Guardian Signature Date

NOTICE 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.

LifeScape Medical Associates, P.C. ("LifeScape") is required by law to maintain the privacy of your protected health information and to provide you with this notice, which explains our legal duties and privacy practices with respect to your protected health information. LifeScape must abide by the terms set forth in this notice. However, LifeScape reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information LifeScape maintains. LifeScape will post any revised notice in a prominent location in our office and, upon request, will provide to you a copy of the revised notice.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Treatment. LifeScape may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. LifeScape may also disclose your protected health information to other health care providers who may be treating you or involved in your health care. For example, LifeScape may disclose your protected health information to a specialist involved in your treatment.

Payment. LifeScape may use and disclose your protected health information to obtain payment for the health care services LifeScape provides you or to determine whether LifeScape may obtain payment for services LifeScape recommends for you. LifeScape may also disclose your protected health information to another health care provider, health care clearinghouse, or health plan for their payment activities. For example, LifeScape may include with a bill to a third-party payer information that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations. LifeScape may use and disclose your protected health information to support our business activities. For example, LifeScape may use your protected health information to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. LifeScape may disclose your protected health information for certain health care operations of another health care provider, health care clearinghouse, health plan for certain health care operations, and to an "organized health care arrangement" LifeScape participates in for its health care operations. LifeScape may also disclose your protected health information to third party business associates who perform certain activities for us (e.g., billing and transcription services). Finally, LifeScape may disclose to certain third parties a limited data set containing your protected health information for certain business activities.

Appointment Reminders and Treatment Alternatives. LifeScape may use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment, or to tell you about or to recommend possible alternative treatments or other health-related benefits or services that may be of interest to you.

Persons Involved in Your Care. LifeScape may use and disclose to a family member, a relative, a close friend, or any other person you identify, your protected health information that is directly relevant to the person's involvement in your care or payment related to your care, unless you object to such disclosure. If you are unable to agree or object to a disclosure, LifeScape may disclose the information as necessary if LifeScape determines that it is in your best interest based on our professional judgment.

Notification. LifeScape may use or disclose your protected health information to notify or assist in notifying a family member, personal representative, or other person responsible for your care of your location, general condition, or death.

Disaster Relief. LifeScape may use and disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Research. LifeScape may use and disclose your protected health information to researchers whose research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. LifeScape may also

disclose to certain third parties a limited data set containing your protected health information for research purposes.

As Required by Law. LifeScape may use and disclose your protected health information to the extent the use or disclosure is required by law. If required by law, you will be notified of any such uses or disclosures.

Public Health. LifeScape may disclose your protected health information for public health activities to a public health authority that is permitted by law to collect or receive the information. Disclosures will be made for purposes of controlling disease, injury, or disability. If directed by the public health authority, LifeScape may disclose your protected health information to a foreign government agency that is collaborating with the public health authority.

Abuse or Neglect. LifeScape may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. If LifeScape believes you are a victim of abuse, neglect, or domestic violence, LifeScape also may disclose your protected health information to the governmental agency that is authorized to receive this information. All disclosures will be consistent with the requirements of the applicable laws.

Communicable Diseases. If authorized by law, LifeScape may disclose your protected health information to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a communicable disease.

Legal Proceedings. LifeScape may disclose your protected health information in the course of any judicial or administrative proceeding; in response to an order of a court or administrative tribunal; to the extent the disclosure is expressly authorized; or, if certain conditions have been satisfied, in response to a subpoena, discovery request, or other lawful process.

Law Enforcement. If certain legal requirements are met, LifeScape may disclose your protected health information to a law enforcement official for law enforcement purposes, including legal processes, identification and location of suspects, fugitives, material witnesses, or missing persons; information regarding victims of a crime; suspicion that death has occurred as a result of criminal conduct; evidence of criminal conduct occurring on our premises; and, in a medical emergency, reporting criminal conduct not on our premises.

Coroners, Funeral Directors, and Organ Donation: LifeScape may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death, or for the coroner or medical examiner to perform other duties authorized by law. LifeScape may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out her duties or in reasonable anticipation of death. Finally, LifeScape may use or disclose your protected health information for facilitating organ, eye, or tissue donation and transplantation.

To Avert a Serious Threat to Public Health or Safety. Consistent with applicable laws, if LifeScape believes using and disclosing your protected health information is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, LifeScape may use and disclose your protected health information. LifeScape may also disclose your protected health information if it is necessary for law enforcement to identify or apprehend an individual.

Military Activity and National Security. When the appropriate conditions apply, LifeScape may use or disclose your protected health information for activities deemed necessary by appropriate military command authorities, for determining your eligibility for benefits by the Department of Veterans Affairs, or to foreign military authority if you are a member of that foreign military service. LifeScape may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation. LifeScape may use and disclose your protected health information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Department of Health and Human Services. As required by law, LifeScape may disclose your protected health information to the Department of Health and Human Services to determine our compliance with applicable laws.

Written Authorization. Except as stated in this notice, LifeScape will not use or disclose your protected health information without your written authorization. You may revoke this authorization at any time, in writing, except to the extent that LifeScape has used or disclosed your information in reliance on the authorization.

Food and Drug Administration. LifeScape may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, or track products; to enable product recalls; to make repairs or replacements; or to conduct post-marketing surveillance.

Inmates. LifeScape may use and disclose your protected health information if you are an inmate of a correctional facility and LifeScape created or received your protected health information in the course of providing care to you.

YOUR HEALTH INFORMATION RIGHTS

Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy. You have the right to inspect and copy the protected health information that LifeScape maintains about you in our designated record set for as long as LifeScape maintains that information. This designated record set includes your medical and billing records, as well as any other records LifeScape uses for making decisions about you. You may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; or protected health information that is subject to law that prohibits access to protected health information. In some circumstances, you may have a right to review our denial.

If you wish to inspect or copy your medical information, you must submit your request in writing to the attention of our Privacy Officer, c/o LifeScape Medical Associates, P.C., 8757 East Bell Road, Scottsdale, AZ 85260. LifeScape may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. You may mail your request or bring it to our office. LifeScape has 30 days to respond to your request for information that LifeScape maintain at our practice sites. If the information is stored off-site, LifeScape has up to 60 days to respond, but must inform you of this delay.

Request Amendment. You have the right to request that LifeScape amend your protected health information. You must make this request in writing to our Privacy Officer. The request must state the reason for the amendment.

LifeScape may deny your request if it is not in writing or does not state the reason for the amendment. LifeScape may also deny your request if the information was not created by us, unless you provide reasonable information that the person who created it is no longer available to make the amendment; is not part of the record which you are permitted to inspect and copy; the information is not part of our designated record; or is accurate and complete, in our opinion.

Request Restrictions. You have the right to request a restriction or limitation of how LifeScape uses or disclose your protected health information for treatment, payment, or health care operations; to persons involved in your care; or for notification purposes as set forth in this notice. Although LifeScape is not required to agree to your requested restriction, if LifeScape does agree, LifeScape will comply with your request unless the information is needed for emergency treatment. Please contact our Privacy Officer as set forth in this notice to request a restriction.

Accounting of Disclosures. You have the right to request a list of our disclosures of your protected health information, except for disclosures for treatment, payment, or health care operations; to you; incident to a use or disclosure set forth in this notice; to persons involved in your care; for notification purposes; for national security or intelligence purposes; to law enforcement officials; as part of a limited data set; that occurred before April 14, 2003 or six years from the date of the request. Your request must be in writing and must state the time period for the requested information.

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, LifeScape may charge you a fee for the costs of providing the subsequent list. LifeScape will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how LifeScape communicates with you to preserve your privacy. LifeScape may condition the accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. You must submit your request in writing to our Privacy Officer. The request must specify how or where LifeScape is to contact you. LifeScape will accommodate all reasonable requests.

File a Complaint. You have the right to file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services if you believe LifeScape has violated your privacy rights. Complaints to our Privacy Officer must be in writing. LifeScape will not retaliate against you for filing a complaint.

For More Information:
If you have questions or would like additional information, you may contact our Privacy Officer at 480-860-5500.

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