# ADALGISA BARISON HOLTROP, MSW

Licensed Clinical Social Worker

phone: (603) 617-3383
dal.holtrop@gmail.com


To Whom It May Concern:

Enclosed, please find the following:

- Patient Information sheet
- Biographical Information sheet
- Symptom Checklist
- Patient Agreement
- New Hampshire Notice Form
- Patient Signature Page
- Authorization Form

I would like to review some information prior to your visit.

-It is important that forms are completed and brought to the office on the day of your scheduled appointment.
-The patient agreement and New Hampshire notice form must be read and signed, prior to meeting with the therapist.
-Please provide your insurance card and a driver's license or form of identification.
-Please complete the enclosed Authorization for Release of Information so I may coordinate care with other health care providers, when needed.
-If you have any questions, please send me an e-mail at dal.holtrop@gmail.com or call at (603)617-3383.

Please be sure to do whatever is necessary to remember and keep your scheduled appointments in order to avoid a charge.

Thank you!

Adalgisa Barison Holtrop, LICSW

**NEW PATIENT INFORMATION SHEET**

How did you hear about my services?
☐ Friend ☐ Doctor ☐ Insurance Provider ☐Psychology Today ☐ Word of mouth ☐ Other:
_____

**The Reasons for your visit:**

How intense is your emotional distress? (Mild) 1 2 3 4 5 (Severe)

Overall, how much do the problems affect your ability to perform at work or school, get along with others, and perform daily tasks? (Mildly disruptive) 1 2 3 4 5 (Incapacitating)

When did these problems start? What was going on in your life at that time?

_____

**General Information**

Name: _____
Date of Birth: _____
Mailing Address: _____
Physical Address: _____
Telephone number: (H)_____ (W) _____
(Cell) _____ (Other) _____
E-mail contact: _____
Emergency contact: _____ phone number _____
Place of Employment: _____
Address (City, State, Zip): _____
Position: _____ ☐ Full Time ☐ Part Time
Not working because: _____

**Billing Information**

Responsible Party Information (if different from patient)
Name: _____ Relation to patient: _____
Address: _____Phone#: _____
Subscriber Date of Birth: _____ Social Security Number: _____
Credit Card Information: _____
(Your credit card will be charged with no show fee of $80 in case of missing appointment without 48-hour notice)
Insurance Company: _____Phone #: _____
Subscriber Name: _____ Employer: _____
Policy Number: _____ Group Number: _____

**Patient Agreement**

I have received the Outpatient Services Agreement, which describes the policies of the office and the professional responsibilities of the therapist. I understand that I am encouraged to discuss any information addressed in this publication with my therapist.

I authorize Adalgisa Barison Holtrop, LICSW to release any or all information to process my insurance claim, INCLUDING DRUG/ ALCOHOL INFORMATION AND COMMUNICATIVE DISEASES (initial here) ** _____**

Insurance claims are sent electronically. If you don't want your claims sent this way, let us know and you can pay at the time of service or submit claims to the insurance company yourself.

I authorize payment of insurance to be made directly to Adalgisa Barison Holtrop, LICSW and acknowledge that I am responsible for any balance not covered by insurance. I AM RESPONSIBLE FOR PAYING FOR A MISSED APPOINTMENT OR ONE CANCELED WITHOUT 48 HOUR NOTICE.

I understand that in order to enhance the quality of care and provide continuity of services, relevant case information may at times need to be shared with other practice clinicians.

Signature of patient or responsible party: _____ Date: _____

Scheduled Appointment Time / Therapist: _____

**BIOGRAPHICAL INFORMATION**

I would like to ask for information that will help me to prepare for your visit and facilitate planning your treatment. If you are hesitant to complete any or all parts of this form, you can discuss this with me during your initial assessment.

Name_____ Date Filled Out _____
Date of Birth _____ Age_____

**Family Information**

| | Name | Age | Serious Illnesses | Year Deceased |
|---|---|---|---|---|
| Parents (mother) (father) | | | | |
| | | | | |
| Siblings | | | | |
| | | | | |
| | | | | |
| Children | | | | |
| | | | | |
| | | | | |
| | | | | |
| Spouse or Partner | | | | |
| | | | | |
| | | | | |

Please note if you are/were particularly close to this person

Any experiences, deaths or major losses in your life that have been particularly hard?

_____
_____
_____

**Education**

Degree(s) earned _____

Any Learning Problems in school?

_____

_____

_____

Any History of Hyperactivity or Behavioral Problems in school?

_____

_____

**Job History (last three years)**

_____

_____

_____

**Medical History**

Present Physician _____ Date of last Physical _____
Previously diagnosed medical conditions: _____

_____

| Year | Condition | Doctor | Treatment |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Any history of head injury? _____
Allergies: _____
Prescription Drugs you are now taking :

_____

_____

_____

Prescription Drugs you have taken recently:

_____

_____

_____

How much alcohol do you drink each day_____ Week_____?
How much coffee do you drink each day _____ Week_____?

V. Prior Psychiatric Treatment

| Date | Doctor | Problem |
|---|---|---|
| | | |
| | | |
| | | |

Name of Psychiatrist: _____ Phone: _____
Practice Name: _____
Address (City, State, Zip): _____ Date of last appointment: _____

Does anyone in your family have a mental illness? ☐ Yes ☐ No

Have you or anyone in your family every attempted or committed suicide? ☐ Yes ☐ No

Does anyone in your family have a substance abuse problem? ☐ Yes ☐ No

Have you ever been arrested? ☐ Yes ☐ No
If "yes" to any of the above, please briefly explain: _____

_____
_____

What are your goals for therapy? What would you like to achieve by attending therapy?

_____
_____
_____
_____

What concerns do you have about attending therapy or working on these problems?

_____
_____
_____
_____
_____

Is there anything else that you would like to mention?

_____
_____
_____

**ADALGISA BARISON HOLTROP, LICSW**

**(603) 617-3383**

**dal.holtrop@gmail.com**

**Psychotherapist-Client Services Agreement**

This document contains important information about professional services and business policies of Adalgisa Barison Holtrop, LICSW. HIPPA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of protected health information for treatment, payment and health care operations. The law requires that I obtain your signature acknowledging that I have provided you with this information by the end of the first session. Although these documents are long and sometimes complex, it is important that you read them carefully. 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.

**PSYCHOTHERAPY SERVICES**

I am a Licensed Independent Clinical Social Worker in the State of New Hampshire and Maine. My Clinical Social Work License number is 1198 NH. My work is consistent with all applicable state laws as well as the professional ethical standards of Association of Social Work Boards.

I work with people on a collaborative basis. Psychotherapy is not easily described in general statements, but it is not like a medical doctor visit. Instead, it calls for a very active effort on your part. It varies depending on the personalities of the client and psychotherapist. 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. Therapy involves a commitment of time, money, and energy.

Psychotherapy can have benefits and risks. Since psychotherapy 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.

**MEETINGS**

In the initial of psychotherapy, an evaluation of your needs will involve two to four 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. By the end of the evaluation, I will be able to offer you some first impressions including if I believe that I would be able to be helpful to you, and if so, what our work could involve. If you are not comfortable with me or I believe to not be of help to you I will provide you with names of other clinicians. If psychotherapy is begun, we determine how frequently we meet based on therapeutic needs, goals, financial feasibility, and a mutual agreement on what frequency best addresses your hopes and concerns. If you have questions about my procedures, we should discuss them whenever they arise.

Once an appointment hour is scheduled, I will reserve the full time for you. If you are late for a session the remaining minutes are yours (i.e., if you are ten minutes late for a 60 minutes session, we will meet for the remaining 50 minutes). You will be expected to pay for it unless you provide 48 hours advance notice of cancellation. **Insurances do not cover missed appointments and repeated missed appointments may necessitate termination of treatment. The no show fee will be $80 dollars and this fee must be paid prior to patient making another appointment after the no show has occurred.**

**PROFESSIONAL FEES**

My evaluation fee is $200.00, and my hourly session fee is $180. In addition, I charge this amount for other professional services you may need. (The hourly cost will be broken down if I work for periods of less than one hour) Other services charged include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay $400 for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party.

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when patient requests them**. I only accept personal checks, cash or direct electronic payments.**

If your account has not been paid for more than 60days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency. The cost of hiring a collection agency and/or legal representation is the responsibility of the client.

**INSURANCE REIMBURSEMENT**

In order for us to set realistic treatment goals and priorities, we must evaluate what resources you have available to pay for your treatment. If you have health insurance, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with assistance in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers and if you have questions about the coverage, call your plan administrator.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am 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. 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. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

**CONTACTING ME**

I can be reached at my cell phone (603) 617-3383 between 9AM and 6PM Monday through Friday.

I cannot guarantee that cell phone communication will be confidential, and not heard by others who may have devices with which they inadvertently pick-up cell communications. It is your responsibility to leave a phone number to which you are comfortable receiving calls. If you prefer that I do not return your call from a cell phone, please be aware that I will do my best to respond to your call as soon as I am able, but it may take me longer to return your call if I am away from a land line. I do not use text messaging as a means of communicating with you. Please indicate your preferences bellow and initial. I do not exchange text.

I authorize permission to be contacted from cell phone line _____

I do not authorize to be contacted from a cell phone line _____

You may leave messages (appointment info only) on my answering machine or voice mail _____

I do not authorize messages to be left for me _____

I am also accessible by e-mail dal.holtrop@gmail.com Please note that e-mail is not a confidential form of communication. Also note that I do not discuss clinical matters in e-mail. I do not use an encrypted e-mail account and cannot guarantee the confidentiality of online communication. If you wish to provide an e-mail address, please do so below and initial that you are aware of the risks and limits of e-mail communication.

E-mail_____initials_____

Appointments can be made by sending me an e-mail. As I do not answer the phone during sessions, I encourage you to leave a voicemail and I will return your call as soon as possible. I will make every effort to return your phone call on the same day you make it, with the exception of weekends and holidays. If you are unable to reach me

and you can't wait for my returning call, please contact your family physician, 911 services or the nearest emergency room. For all medical emergencies please dial 911, go to or contact your local emergency room, or contact your primary care physician. If I am off for the day or away, I will usually indicate this to my clients. Usually, I take a long yearly vacation about 4 to 8 weeks, which I will inform, my clients ahead of time. Coverage and appropriate treatment management for these times will be discussed and referred to clients. Snow cancellations will also be announced via telephone contact or e-mail.

Electronic submission of information- This office uses electronic submission of certain bills to third party payors. If you have questions regarding this practice, please speak to Adalgisa Bariosn Holtrop. You may also find information in HIPAA documents.

**LIMITS ON CONFIDENTIALITY**

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

- I may occasionally find helpful to consult with other health and mental health professionals about a case. During these consultations, I make every effort to avoid revealing the identity of my clients. The consultants are legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that is important to our work together. By signing this document, you are acknowledging that you understand that I may discuss your case in consultations and do not object to my doing so.
- I also have contracts with legal, accounting, electronic billing, phone, answering and computer service companies. Usually, patient information is not disclosed but it can occur. As required by HIPAA, these businesses promise to maintain the confidentiality of this data except when required by law. If you have concerns, please discuss it with me.

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

- If you are involved in a court proceeding and a request is made for information concerning the professional services, I provided you and/or the records thereof, such information is protected by the therapist-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself. Confidentiality is also waved in the event your account is past due 60 days and I am required to contact a collection agency and/or obtain legal representation.

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 include:

- Child Abuse
- Adult and Domestic Abuse
- Serious Threat to Health or Safety

Please see the Notice Form provided for more details. 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, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

**MINORS & PARENTS**

Unless informed otherwise, I assume that every child has two parents with equal legal rights to initiate treatment, make treatment decisions, receive and disseminate information from the child's medical record, and communicate with me. I hope that each parent will seek to keep the other parent informed of the decision to engage in the evaluation, the treatment plan and the progress of their child. Should one parent's rights be limited or terminated, or if a court has ordered that both parents must give consent for treatment, it is the parent's responsibility to provide documentation from the court showing the limits on, or termination of, parental rights.

**PROFESSIONAL BOUNDARIES**

Licensed psychotherapists are obligated to establish and maintain appropriate professional boundaries (relationships) with present or past clients (and, in some cases, client's family members). For example, therapists should not socialize or become friends with clients and should never become sexually involved with a client.

**INTELLECTUAL PROPERTY**

In order to honor and protect the therapist's intellectual property, (you) the client agree not to disclose or communicate information about the therapist's materials, written articles, or methods to any third parties without express permission. Adalgisa Barison Holtorp will also protect any client intellectual property or personal/business information that may be discussed. Sessions or services delivered should not be recorded without mutual written consent from client and professional.

**CONCERNS AND COMPLAINTS**

If you have any complaints about treatment you have received or about billing, you should not hesitate to raise them with me.

I have read and understand and accept the provisions described in this Agreement.

_____ _____

Signature of Patient/ Legal Representative Date

_____ _____

Adalgisa Barison Holtrop, LICSW Date

**NEW HAMPSHIRE NOTICE FORM**

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

This is a summary of information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law 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 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.

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations "
  - Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization " is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes " are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1)1 have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If I have a reason to suspect that a child has been abused or neglected, I am required by law to report this to the Bureau of Child and Family Services.
- Adult and Domestic Abuse: If I suspect or have a good faith reason to believe that any incapacitated adult has been subject to abuse, neglect, self neglect or exploitation, or is living in hazardous conditions, I am required by law to report that information to the Commissioner of the Department of Health and Human Services.
- Health Oversight: If the New Hampshire Board of Psychological Examiners is conducting an investigation,

then I am required to disclose your mental health records upon receipt of a subpoena from the Board.

- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that I provided you and/or the records thereof, such information is privileged under state law, and I may not release information without your written authorization, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance, if this is the case.
- Serious Threat to Health or Safety: If you have communicated to me a serious threat of physical violence against a clearly identified or reasonably identifiable victim or victims, or if you have made a serious threat of substantial damage to real property, I am required by law to take reasonable precautions to provide protection from such threats by warning the victim or victims of your threat and to notify the closest police department. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance, if this is the case.
- Serious Threat to Health or Safety: If you have communicated to me a serious threat of physical violence against a clearly identified or reasonably identifiable victim or victims, or if you have made a serious threat of substantial damage to real property, I am required by law to take reasonable precautions to provide protection from such threats by warning the victim or victims of your threat and to notify the police department closest to your residence or the potential victim's residence, or obtain your civil commitment to the state mental health system.

## IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- Right to Request Restrictions - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- Right to Inspect and Copy - You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.
- Right to Amend - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- Right to an Accounting- You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- Right to a Paper Copy - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychotherapist Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

## V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact Adalgisa Barison Holtrop
You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

## VI. Effective Date. Restrictions and Changes to Privacy Policy

This notice will go into effect on December 5, 2009.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by written notice through the mail.

**Adalgisa Barison Holtrop, MSW, LICSW**

**Maine**

# 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.

Each time you visit us, we keep a record of your care and treatment. We take the protection of your personal information seriously. We are required to provide you with this Notice of Privacy Practices to tell you about our legal duties and ways we may use and share your information, and to inform you about your rights regarding your health information. We give a small number of examples to describe what the categories mean, but not every use or disclosure can be listed on this Notice.

You have a right to a paper copy of this Notice of Privacy Practices.

This Notice is effective as of: September 1, 2014. We will ask you to sign a written acknowledgment of receipt of our Notice. We reserve the right to change the terms of this Notice and post the current Notice in our office. You may obtain an updated Notice from our practice at any time.

If you have any questions about this Notice of Privacy Practices, please contact Adalgisa Barison Holtrop, telephone: 1-207-844-4887

How We May Use and Disclose Protected Health Information:

For Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and related services in our office or with a third party. For example, we may share your protected health information with a pharmacy for filling prescriptions, a laboratory or imaging center if you need diagnostic services, with a specialist to whom we refer you, or with a home health agency that provides care to you. We may share information with persons involved in your care, such as family members.

For Payment: We will use your protected health information to get paid for your healthcare services. We may share information with your insurance company to obtain payment for services or to seek pre-approval for a hospital stay or procedures.

For Our Healthcare or Business Operations: We may disclose your protected health information to support the business activities of this office, such as reviewing our care and our employees, for education and training, to support our electronic health record system, or for legal or accounting matters. We may use a sign-in sheet at the registration desk so that we may call you by name when we are ready to see you, and we may contact you to remind you of your appointment. If we involve third parties, such as billing services, in our business activities, we will have them sign a "business associate agreement" obligating them to safeguard your protected health information according to the same legal standards we follow.

When Allowed by Law: The law allows us to use or disclose your protected health information in certain situations, including:

- When required by state or federal law.

- To report abuse or neglect.
- To persons authorized by law to act on your behalf, such as a guardian, health care power of attorney or surrogate.
- For disaster relief purposes, such as to notify family about your whereabouts and condition.
- For public health activities such as reporting on or preventing certain diseases.
- To comply with Food and Drug Administration requirements.
- For health oversight purposes such as reporting to Medicare, Medicaid or licensing audits, investigations or inspections.
- Where required by U.S. Department of Health and Human Services to determine our compliance.
- In connection with Workers' Compensation claims for benefits; and
- To assist coroners or funeral directors in carrying out their duties.
- To comply with a valid court order, subpoena or other appropriate administrative or legal request if you are involved in a lawsuit or to assist law enforcement where there was a possible crime on the premises. We may also share your information where necessary to prevent or lessen a serious or imminent threat to you or another.
- If you are an inmate, we may release your information for your health or safety in the correctional facility; We may share your information with appropriate military entities if you are a member or veteran of the armed forces; We may be required to disclose information for national security or intelligence purposes.

With your Authorization: Other uses and disclosures will be made only with your written authorization. For example, we will ask for your written permission before promoting a product or service to you for which we will be paid by a company, and generally before sharing your health information in a way that is considered a sale under the law. If you sign an authorization, you may revoke it at any time, except where we have already shared your information based upon your permission.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to access, inspect and copy your protected health information.

- This usually includes medical and/or billing records. You must submit a written request to us, and you agree to pay the reasonable costs associated with complying with your request before we provide you with your record
- You may ask us to provide your electronic record in electronic format. If we are unable to provide your record in the format you request, we will provide the record in a form that works for you and our office. You may ask us to transmit your record to a specific person or entity by making a written, signed request. You may request the information be sent via our email system if you sign a statement that you understand that email comes with inherent risks for which our office is not responsible.
- Under certain circumstances, your provider may not allow you to see or access certain parts of your record. You may ask that this decision be reviewed by another licensed professional.

You have the right to request to receive confidential communications, and request contact from us by alternative means or at an alternative location.

You have the right to request a restriction of your protected health information.

- This means you may ask us not to use or disclose all or part of your protected health information for certain purposes. We will consider your request carefully, and may honor reasonable requests where possible. The law does not require us to agree to every request.
- However, if you wish to restrict certain sensitive or other health information from your insurer after you or your personal representative have paid out of pocket in full for your services, please discuss this request with us. We will honor your request where we are not required by law to make the disclosure. If your insurance plan "bundles" your services together so that we cannot withhold only one item or service from your claim, we will discuss your options with you.
- You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to receive an accounting of certain disclosures we have made of your protected health

information. Please speak with us if you have this request.

You may have the right to request amendment of your protected health information. While we cannot erase your record, we may add your written statement to your protected health information to correct or clarify the record where your provider approves. If the provider disapproves, you may submit a statement of disagreement and we may submit a rebuttal, which will remain with your record.
Breach notification. We are required to have safeguards in place that protect your health information. In the event that there is a breach of those protections, we will notify you, the U.S. Department of Health and Human Services and others, as the law requires.
You may file a complaint with us by notifying our Privacy Officer with your written complaint. We will not retaliate against you for filing a complaint with us or the Office of Civil Rights.
You may complain to the Office of Civil Rights at the Department of Health and Human Services (OCR) if you believe your privacy rights have been violated by us. You should contact the OCR in writing at: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

**ADALGISA BARISON HOLTROP, LICSW**
**(603) 617-3383**
**dal.holtrop@gmail.com**

## PATIENT SIGNATURE PAGE

_____ _____
Print name of patient Date

I have read and accept the **OUTPATIENT SERVICES AGREEMENT.**

** _____ _____
Signature of Patient Date

_____ _____
Signature of Legal Guardian (if appropriate) Date

I have RECEIVED the HIPAA privacy policy (**NEW HAMPSHIRE NOTICE FORM)**

** _____ _____
Signature of Patient Date

_____ _____
Signature of Legal Guardian (if appropriate) Date

**I understand the office policy for MISSED APPOINTMENTS and that I will be responsible for up to the full session fee if I do not provide 48 office hours' notice of cancellation.**

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Guardian (if appropriate) Date

**ADALGISA BARISON HOLTROP, LICSW**

**(603) 617-3383**
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## AUTHORIZATION FORM

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

Patient Name: _____DOB: _____

I authorize my clinician, _____and/or his or her administrative and clinical staff to release the following clinical information to: (name and address of person to whom the information is to be released):

Name: _____ Phone #: _____

Address: _____Fax #: _____

Information to be Disclose

_____Psychiatric/ psychological evaluation _____Progress Notes

_____Other: _____

Methods of Disclosure Authorized

_____Faxed _____Written _____Phone Conversation _____ In Person _____E-Mail

This authorization is effective until _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. Revocation will be effective as of the date received. I understand that a revocation will not be effective to the extent that the provider has taken action in reliance on the authorization prior to the revocation date, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurance coverage and the insurer has a legal right to contest a claim.

I understand that my clinician generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I understand that I have the right to inspect and copy the disclosed information and to refuse to sign this authorization.

SIGNATURE OF PATIENT: _____DATE: _____

I authorize the release of drug and/or alcohol diagnosis and treatment information.

SIGNATURE OF PATIENT: _____DATE: _____

If a personal representative of the patient signs the authorization, a description of such representative's authority to act for the patient must be provided. _____

To the Receiving Provider: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical information or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or persecute any alcohol or drug abuse patient.