



REGISTRATION INFORMATION – ADULT

How did you hear about us?

CLIENT INFORMATION

CLIENT FULL NAME		DATE OF BIRTH	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> PARTNERED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> OTHER	EMPLOYMENT STATUS <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> SELF-EMPLOYED <input type="checkbox"/> RETIRED <input type="checkbox"/> ACTIVE MILITARY <input type="checkbox"/> OTHER		STUDENT STATUS <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME
ADDRESS		CITY/STATE/ZIP	
HOME PHONE	CELL PHONE	WORK PHONE	INDICATE BEST # TO LEAVE MSG <input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> WORK
EMAIL ADDRESS	OK TO DISCUSS SCHEDULING VIA EMAIL? <input type="checkbox"/> YES <input type="checkbox"/> NO OK TO SEND RECEIPTS OR STATEMENTS VIA EMAIL? <input type="checkbox"/> YES <input type="checkbox"/> NO		

EMERGENCY CONTACT

EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE	RELATIONSHIP TO CLIENT
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RESPONSIBLE PARTY 1 (IF DIFFERENT THAN CLIENT)

BILLING FULL NAME	RELATION TO CLIENT <input type="checkbox"/> LEGAL GUARDIAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT OF 18+ DEPENDENT <input type="checkbox"/> OTHER		
BILLING ADDRESS	CITY/STATE/ZIP		
BILLING PHONE	LEAVE MSG? <input type="checkbox"/> YES	EMAIL ADDRESS	OK TO SEND RECEIPTS OR STATEMENTS VIA EMAIL? <input type="checkbox"/> YES <input type="checkbox"/> NO

RESPONSIBLE PARTY 2 (IF DIFFERENT THAN CLIENT)

BILLING FULL NAME	RELATION TO CLIENT <input type="checkbox"/> LEGAL GUARDIAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT OF 18+ DEPENDENT <input type="checkbox"/> OTHER		
BILLING ADDRESS	CITY/STATE/ZIP		
BILLING PHONE	LEAVE MSG? <input type="checkbox"/> YES	EMAIL ADDRESS	OK TO SEND RECEIPTS OR STATEMENTS VIA EMAIL? <input type="checkbox"/> YES <input type="checkbox"/> NO

INSURANCE INFORMATION Copy of both sides of the insurance card(s) needed at intake.

Please file to my insurance as listed below I do NOT wish to file insurance (self-pay) I do NOT have mental health coverage (self-pay)
 **Does your insurance require pre-certification, an authorization or referral from your Primary Care Physician? Yes No

PRIMARY INSURANCE COMPANY		SECONDARY INSURANCE COMPANY		DOES YOUR EMPLOYER HAVE AN EMPLOYEE ASSISTANCE PROGRAM (EAP)? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Policy Holder's Name & Date of Birth:		Policy Holder's Name & Date of Birth:				
COPAY: \$	*DEDUCTIBLE: \$	CO-INSURANCE: %	COPAY: \$	*DEDUCTIBLE: \$	CO-INSURANCE: %	DO YOU HAVE HRA ACCOUNT ASSOCIATED WITH YOUR INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO

ALL COPAYS AND BALANCES ARE DUE IN FULL AT THE TIME OF YOUR APPOINTMENT

***Please make all checks payable to: ISI Therapeutic Family Services, LLC**

My signature below gives ISI Therapeutic Family Services, LLC permission to use PayPal or Square to collect any fees or copays etc.

Cardholder Signature:	Date:
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PRIVATE PAY and FILING to DEDUCTIBLE Payment due IN FULL at the time of service.



IMPORTANT SIGNATURES

CLIENT FULL NAME		DATE OF BIRTH
<i>if client is a minor, please print name of parent/guardian(s) signing on behalf of the client:</i>		
PRINT FULL NAME	RELATIONSHIP TO CLIENT	
PRINT FULL NAME	RELATIONSHIP TO CLIENT	
MISSED APPOINTMENTS		
I am financially responsible for my attendance at all scheduled appointments, unless cancelled with <u>at least</u> 24 hour notice. <u>Minimum</u> charges of \$100 will be applied to my account for a late cancel and \$100 for a no-show. This charge is NOT covered by insurance.		
INSURANCE BILLING		
I authorize ISI Therapeutic Family Services, LLC to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to ISI Therapeutic Family Services, LLC. I understand that I am responsible for payment for services rendered by ISI Therapeutic Family Services, LLC regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify ISI Therapeutic Family Services, LLC immediately whenever I have changes in my health plan coverage.		
ACCOUNT RESPONSIBILITY		
I am responsible for payment to ISI Therapeutic Family Services, LLC for all services rendered, due at the time of the visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. If I default on any payment obligations as called for in this agreement, ISI Therapeutic Family Services, LLC reserves the right to forward my information to collections, and an additional 30% may be assessed to my account to cover the costs of this action. There will be no obligation to provide continuing services to any client who names ISI Therapeutic Family Services, LLC as a creditor in any bankruptcy filing.		
LITIGATION LIMITATION		
Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.		
RECORDS RELEASE – Primary Care Physician		
<input type="checkbox"/> I do not have a Primary Care Physician <input type="checkbox"/> I do not want ISI Therapeutic Family Services, LLC to release my information to my Primary Care Physician at this time <input type="checkbox"/> I request ISI Therapeutic Family Services, LLC to release my information to my Primary Care Physician. If so, please complete the included Release of Information form.		
CLINICAL STAFF RELEASE		
I understand that as part of professional clinical consultation, my situation may be reviewed using general clinical information, and that my therapist will obtain a signed Release of Information (ROI) prior to discussing specific details of my situation.		
INFORMED CONSENT & NOTICE OF PRIVACY PRACTICES		
I am consenting to treatment and have received and understand the contents of the Counseling Policies, including the Notice of Privacy Practices (HIPAA).		
<i>My signature below indicates that I have been offered a copy of, and that I fully understand & agree to all of the terms and conditions of the Counseling Policies. If I have questions, the information has been explained and/or summarized for me.</i>		
SIGNATURE(S) (CLIENT OR LEGAL GUARDIAN)		DATE
SIGNATURE(S) (LEGAL GUARDIAN)		DATE



**PRIMARY CARE PROVIDER NOTIFICATION OF CLINICAL SERVICES
AND CONSENT FOR THE RELEASE OF INFORMATION**

Continuity and coordination between physical and mental health is an important aspect in the delivery of quality health care, as mental and physical disorders can interact to affect an individual's health.

PATIENT INFORMATION

PATIENT NAME	DATE OF BIRTH	INTAKE DATE
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PRIMARY CARE PROVIDER/CLINIC

PHONE	FAX
ADDRESS	CITY/STATE/ZIP

MENTAL HEALTH PROVIDER INFORMATION

Dear Primary Care Provider,
I am sending this form to notify you that I am currently seeing your patient in a therapeutic setting and to provide our offices with a release of information to facilitate communication and to coordinate services in regards to client care. If further information is desired, please contact me at your convenience.

MAILING ADDRESS:
ISI Therapeutic Family Services, LLC
2208 Executive Park Drive
Opelika, AL 36801

Sincerely,

Charles 'Chad' Smith, M.A., LMFT

CLINICAL INFORMATION

REASON FOR REFERRAL OR CARE COORDINATION

DIAGNOSIS	MEDICATIONS
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TREATMENT PLAN(S) OR RECOMMENDATIONS

CONSENT AND RELEASE

I authorize the exchange of information regarding my clinical care needed to coordinate treatment with my primary care physician. I understand that my records are protected under the Federal and specific State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., the provision of treatment upon consent to disclose third party payers) and that this consent expires automatically as described below. Information to be released includes diagnosis, treatment procedures and details of my condition which help to coordinate treatment. I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. This release is valid for 1 year after last contact and I may cancel it in writing at any time.

SIGNATURE(S)	DATE
SIGNATURE(S)	DATE



COUNSELING POLICIES

Please carefully read through the following Counseling Policies. This document contains important information about our professional services and business policies, as well as responsibilities and expectations of you as the client. When you sign the IMPORTANT SIGNATURES page of this document, it represents your understanding of all the rules and responsibilities of both the client and the therapist, in addition to understanding the financial terms and agreements.

Welcome to ISI Therapeutic Family Services, LLC!

We are grateful to have the opportunity to offer services to you and hope this form will assist your decision in pursuing counseling.

We are a professional mental health counseling group. Within this model, your therapist is your primary point of contact for scheduling & account management (payment, statement/receipt requests, & billing questions). Our business office provides administrative support to your therapist. To update your personal and/or insurance information or if you are having difficulty scheduling online, please contact [Christy Lessley](mailto:Christy.Lessley@isitherapy.com) at christy@isitherapy.com.

What is therapy and how does it work?

The Counseling Relationship. Each person who seeks counseling comes with unique experiences and concerns. The relationship of counselor to counselee will be characterized by professional dignity, expertise, warmth, and acceptance. Therapy is a learning process and a process of change that seeks for the persons involved to better understand themselves and others as well as the interactions that occur between the participants and significant others. Equally important is to achieve enhanced functioning as an individual, couple, or family so that healthy interactions are established and greater satisfaction is attained. Our therapeutic approach is eclectic, depending on the type of problem being addressed. While we are systemic in nature, we gravitate toward cognitive-behavioral therapy, solution-focused brief therapy, family systems, and structural family therapy. Our approach is straightforward and based upon the counselee's goals. Techniques may involve visualizations and/or material drawn from spiritual disciplines. In addition, the holistic nature of our views concerning mental health recognizes a person's spirituality as a vital component and the central organizing principle around which lasting mental health and strong relationships may be achieved. Initially in the therapeutic process, we will explore the background of focal issues. Although it may be a painful process at times, success is dependent on client honesty. Our hope early in therapy is to instill trust within the client/therapist relationship. Once this foundation has been adequately established, we will develop specific goals and a plan by which these goals will be achieved. We will jointly assess objective achievement on a regular basis to determine if significant change in the treatment plan needs to be made. Termination of therapy will result when the client and therapist agree the goals have been achieved, at the client's request, or when another therapist might better meet the needs of the client.

INTAKE APPOINTMENT

Since your therapist is your primary contact, you will not need to check in with a receptionist upon arrival. Please take a seat in our waiting area and your therapist will greet you for your appointment. Please bring the following REQUIRED items to your intake appointment:

- Completed and Signed Counseling Policies forms
- Completed Personal History form
- Photo ID (of legal guardian, if client is a minor)
- Insurance card(s)
- Payment for copay or other financial responsibility (cash, check, credit/debit card, or HSA card)

If you are unable to complete, or forget to bring your forms, please arrive a minimum of 15-20 minutes early to complete forms located in the waiting area. *The time allotted for the appointment cannot be extended due to incomplete forms.*

All forms will be reviewed during your intake session and the remaining time will be spent talking about what brought you in for counseling. Your therapist will focus on hearing your story and asking questions to better understand your particular struggle and/or situation. This is also a time to measure how comfortable this feels and if this is a good "fit" between you and your therapist.

By the end of your first session, you can expect some feedback from the therapist and both of you will agree on a "game plan" for therapy. If you have any questions, feel free to ask your therapist during your appointment.



UNATTENDED CHILDREN

We are unable to provide supervision for children in the waiting room and cannot accept responsibility for their safety if left unattended.

For the safety and welfare of the children and out of consideration for others, please make arrangements for childcare during therapy sessions, or provide adult supervision for children while waiting in the waiting room.

Parents will be held responsible for any property damage caused by their child

CONFIDENTIALITY POLICY

The staff and therapists at ISI Therapeutic Family Services, LLC have an obligation to respect your right to confidentiality for the information you share within this clinical setting. Confidentiality of client information is governed by federal law (Health Information Portability and Accountability Act) and by state law.

The State of Alabama laws impose some limitations to your rights to confidentiality. The following is a list of situations in which you may lose your right to confidentiality:

- ✓ We are obligated to report any maltreatment of minors or vulnerable adults. This includes physical abuse, sexual abuse or neglect.
- ✓ We are obligated to report any prenatal exposure to controlled substances.
- ✓ We are obligated to report any serious harm you intend to inflict on yourself or another.
- ✓ We are obligated to share information if directed by Court Order to conform to state or federal law, rules or regulations.

If you are a minor, you have a limited right to privacy in that your parents may have access to your records. Minor clients have rights to complete confidentiality in obtaining counseling for pregnancy & associated conditions, sexually transmitted diseases, & information about drug and alcohol abuse. However, if the therapist believes that sharing this information will be harmful to you, confidentiality will be maintained to the limits of the law.

There are instances in which administrative individuals associated with ISI Therapeutic Family Services, LLC have duties that require access to the information you may share for claim processing, scheduling, reports, consultations, etc.

In keeping with standards of practice, your therapist may consult with other mental health professionals within this group private practice regarding care and management of cases. The purpose of this consultation is to ensure quality of care. Your therapist will maintain confidentiality and protect your identity by not using real names or any identifying information. Therapists seeing members of your family or your significant others will obtain a signed Release of Information (ROI) prior to discussing specific details of your situation.

IN CASE OF EMERGENCY

Since we provide outpatient diagnostic and psychotherapy services only, we cannot guarantee around-the-clock availability. Phone calls made after hours will be handled by our voice mail system and returned the following day. Therefore, if you should experience an emotional or behavioral crisis, and we cannot be reached immediately by telephone, you should contact a local medical or psychiatric hospital or call 911. East Alabama Medical Center is located at 2000 Pepperell Parkway, Opelika, AL 36801. The crisis center contact is: 1-800-815-0630.

TELEPHONE & EMAIL COMMUNICATION

Voicemail is available between sessions. Messages will be returned as soon as possible during business days. Please do not rely on your therapist's voicemail in times of crisis or for an emergency.

A prorated charge is applicable to time spent with you on the telephone by your therapist beyond appointment scheduling or similar matters (lasting more than 5 min). Telephone sessions between sessions may be scheduled in advance, based on availability of both parties.

Email should ONLY be used for scheduling purposes and may not be checked on a daily basis. Email correspondence is not considered to be a confidential medium of communication and your therapist is not responsible for any information transmitted via email.



INSURANCE BILLING: Please email us at christy@isitherapy.com to update insurance or registration information.

We are in-network providers for most major insurance companies. Please call your insurance company before your first appointment to verify if we are in-network and to see if you need prior authorization or a referral from your primary care physician. We are NOT in-network with Medicare or Medicaid. As a courtesy to you, we work directly with your insurance company.

Once we receive your in-take packet, we will verify your coverage and any necessary authorizations. If your insurance requires a referral from your primary care doctor, it is your responsibility to obtain a referral PRIOR to your first appointment with us. Verification of coverage is not a guarantee of claim payment. Coverage is subject to the terms and conditions (e.g. authorizations, network requirements) outlined in your member contract with your insurance company.

It remains your responsibility to understand your plan's limitations, deductibles and exclusions. For benefit coverage questions, please call the customer/member service number on the back of your insurance card. We have no authority to make specific representations to you regarding coverage of services.

It is your responsibility to provide us with updated information when your insurance policy changes or your coverage terminates. If the insurance information you provide to us is later determined to be inaccurate, resulting in denial of your claim, then you will be responsible for paying the amount of the denied claim.

If you attend any appointment without obtaining a referral, if required, you are responsible to pay the private pay fee for services at the time of your visit.

There may be instances in which you will need to communicate directly with your insurance company to ensure a smooth billing process. If your insurance requests information regarding Coordination of Benefits (CoB) or Pre-existing Conditions, please promptly return any forms or call your insurance company directly to follow up. Once they request this information from you, all claims deny, and become your full financial responsibility until you provide the documentation requested. Please email us at christy@isitherapy.com to let us know you have resolved any CoB or Pre-existing Condition requests so that we can have your insurance reprocess the denied claims immediately.

ACCOUNT RESPONSIBILITY

Because we are a "fee for service" provider, billing statements from ISI Therapeutic Family Services, LLC will NOT automatically be sent. Should you need a statement or itemized receipt, please inform your therapist, and we will provide this for you upon request within 7 business days.

Per your agreement with your insurance company, it remains your responsibility to *immediately* pay any copayments, deductibles, coinsurances or other amounts your insurance carrier determines as payable by you. This payment is to be collected by your therapist. We do not have the ability to waive copayments, deductibles, or coinsurance amounts due, as this is a violation of the contract we have with your insurance company.

Cost estimation tools provided by your insurance company allow the collection of coinsurance and deductible amounts **up front at the time of service**, rather than waiting until after the claim is processed. This collected payment is based on an *estimate* of your out-of-pocket costs for services provided. Actual coverage and member liability amounts are determined once the claim is processed and you receive an explanation of benefits (EOB). Any overpayments will be applied to ongoing balances or refunded within 90 days of claim processing. Any underpayments must be paid by mail, online at our website, or at your next scheduled appointment (if scheduled appointment occurs within 1 week of receiving your EOB).

To ensure proper credit, please make checks payable to ISI Therapeutic Family Services, LLC. There will be a **\$40 fee for returned checks**. Thereafter, payment will only be accepted in the form of cash, credit card or money order.

You are responsible for charges not eligible and/or covered by your medical insurance plan. If you discontinue care for any reason, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Should you default on any payment obligations, we reserve the right to forward your information to collections, and an additional 30% may be assessed to cover the costs of this action.

We are not obligated to provide continuing services in the event that ISI Therapeutic Family Services, LLC is named as a creditor in any bankruptcy filing.



MISSED APPOINTMENTS

We realize that on occasion you will not be able to make a scheduled appointment. However, please remember that your therapist has reserved this time for you alone, so our policy is to charge **a minimum of \$100 for missed appointments or for cancellations without AT LEAST 24-hour advance notice**. It is up to your therapist’s discretion to require *more* than a 24-hour notice or to charge a *higher* rate for missed appointments.

This charge is NOT covered by insurance and will be billed as your responsibility. Please help us serve you better by keeping scheduled appointments. *Clients with more than one missed appointment may be subject to same day scheduling and/or termination of care.*

MAKING PAYMENTS

Please understand that payment of your bill is considered a part of your treatment. If mailing, please remit payment to:

ISI Therapeutic Family Services
2206 Executive Park Drive
Opelika, AL 36801

Online payments: You may pay by mail, check, Venmo (@Chad-Smith-118) or *PayPal* at isitherapybiz@gmail.com

FEES

Service/Insurance Code	Description	Unit	Rate
Not Billable to Insurance	Late Cancellation / No show	n/a	\$100
Not Billable to Insurance	Returned Check (NSF)	n/a	\$40
Not Billable to Insurance	Phone calls, Letters, & Reports	15 min	\$25+
Not Billable to Insurance	Court Appearances	Day	\$1000

PREPARATION OF FORMS AND REPORTS

These require chart review and often, discussion with the client. A prorated charge is applicable to time spent and is not billable to your insurance.

RELEASE OF RECORDS

Most of the information a clinician collects about you will be classified as confidential. However, when insurance is involved ISI Therapeutic Family Services, LLC does not have control over and cannot assure its clients of confidentiality. That means employees of the insurer and employees of contracted organizations of the insurer have access to your chart. This is provided for in the insurance policy between you and your insurance company. The client record is legally the property of ISI Therapeutic Family Services, LLC. However, clients may have access to information contained in the file, except in those cases where the release of such information may be deemed harmful to the client’s well-being. Information can be released to others only upon written informed consent of the client. In a few cases, information is unavailable to a client. Certain confidential data may be available only to the clinician and particular government agencies. Classified material falling into this category might deal with adoption, civil or criminal investigations, some medical data and the names of persons who report suspected abuse of children or vulnerable adults. In the event of request for transfer of records, the records will be forwarded upon completion of a Release of Information form and a payment fee based on the current AL Code Title 12 Courts 12-21-6.1*. Copies of records are available for \$1 per page for the first 25 pages, not more than 50 cents for each page in excess of 25 pages and a search fee of \$5, plus the actual costs of mailing the medical records.



****COURT & LEGAL PROCEEDINGS**

ISI does NOT provide disability determination, custody studies, or handle court issues.

- ISI providers do not perform court evaluations nor do they appear in court on behalf of individuals, children or adults. ISI services are designed to assist in alleviating problems through individual or relational psychotherapy. ISI providers are not trained for, nor do they maintain records with the intended purpose of court involvement.
- In addition, the legal process is such that we may be compelled to reveal information about you that could affect you negatively or undermine your relationship with your therapist. Because the client-therapist relationship is built on trust with the foundation of that trust being confidentiality, it is often damaging to the therapeutic relationship for the therapist to be asked to present records to the court, testify whether factual or in an expert nature, in court or deposition.
- Should we be called to court by a judge court order, or our records court ordered or subpoenaed, we will charge the full amount applicable under law for our services.
- In the event that it is necessary, by court order or by subpoena, for the therapist to testify before any court, arbitrator, or other hearing officer to testify at a deposition, whether the testimony is factual or expert, or to present any or all records pertaining to the counseling relationship to a court official, the client agrees to pay the therapist for his or her services, (including but not limited to: travel, necessary expenditures (copies, parking, meals, and the like), time spent speaking with attorneys, reviewing records and preparation of reports) at the rate of \$1,000 per day.
- The client further agrees to pay a retainer fee of \$1,000.00 two weeks prior to the appearance, presentation of records, or testimony requested. Checks will not be considered an acceptable form of payment for these services.
- **Litigation Limitation:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your therapist at ISI to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. **My informed consent signature shows that this litigation limitation is clearly understood and agreed to.**

CLIENT BILL OF RIGHTS

ISI does not discriminate on the basis of religion, race, gender, marital status, age, sexual orientation, national origin, previous incarceration, disability or public assistance status.

Every client:

- shall be informed prior to, or at the time of, the intake appointment of services available at ISI and of any financial charges that are the client's responsibility to pay beyond the coverage of health insurance.
- can expect complete and current information concerning his or her diagnosis and individual treatment plan in terms he or she can understand.
- shall have the right to know by name, and the competencies of, the licensed mental health professional responsible for coordination of his or her treatment.
- shall have the freedom to place grievances and recommend changes in policies and services to ISI staff free from restraint, interference, coercion, discrimination, or reprisal.

In addition to the rights listed above, services offered by practitioners licensed by the State of Alabama have the right to: (a) expect that a practitioner has met the minimal qualifications of training and has the experience required by state law; (b) examine public records which contain the credentials of the practitioner; (c) obtain a copy of the rules of conduct.

Every client:

- has the right to be informed of and to refuse to participate in any experimental research.
- may expect courteous treatment and to be free from verbal, physical, or sexual abuse by ISI staff.
- has the right to a coordinated transfer of care when there will be a change of providers.
- may assert the client's right(s) without retaliation.
- has the right to choose freely among available mental health professionals and practitioners in the community and to change providers after mental health services have begun within contractual limits of the client's health insurance (if any).



COMMENTS, QUESTIONS, CONCERNS

We value your opinion and strive to provide the best service possible. If you would like to share your comments, questions, or concerns, please contact our administrative department by phone 334-703-2095 or email at admin@isitherapy.com.

NOTICE OF PRIVACY PRACTICES (HIPAA)

HIPAA Privacy, Security, and Breach Basics (2026)

Our office follows the Health Insurance Portability and Accountability Act (HIPAA), which protects the privacy and security of your health information and gives you rights over your medical records.

How We Use and Share PHI (Personal Health Information)

We may use or share PHI without written permission for:

- Treatment - coordinating your care with other providers.
- Payment - billing you, your insurance, or other payers.
- Health care operations - quality improvement, staff training, and administrative tasks.

We may also share PHI when required by law, such as for public health reporting or safety concerns. Uses for marketing, most psychotherapy notes, or selling PHI require written authorization.

Your Rights Under HIPAA

You may:

- Request and receive copies of your records.
- Ask for corrections if information is inaccurate.
- Request limits on how we use or share PHI (we may not always be able to agree).
- Request confidential communication methods.
- Receive a list of certain disclosures made in the past six years.
- Request a paper copy of our full Notice of Privacy Practices.

Our Responsibilities

We must:

- Protect the privacy and security of your PHI.
- Provide a Notice of Privacy Practices.
- Use safeguards for electronic PHI, including staff training and secure systems.
- Assess and reduce risks, including risks from online tracking technologies.

Breach Notification

If your unsecured PHI is compromised, we will notify you in writing within 60 days, explain what happened, what information was involved, and steps you can take. We also notify federal regulators and, when required, the media.

Special Protections

Some information-such as mental health, substance use disorder, HIV status, and reproductive health care-may have additional protections under federal or state law.

Questions or Complaints

You may file a complaint with our Privacy Officer or the U.S. Department of Health and Human Services Office for Civil Rights. We will not retaliate for filing a complaint.