Samaritan
Center of Puget Sound

# Instructions for Completing Intake Paperwork

*Welcome to Samaritan Center of Puget Sound. Please take a few minutes to complete the following paperwork in this packet before you meet with your therapist.*

**Client Referral Information***
Complete one of these forms. This helps us know how you heard about Samaritan Center and if you would like us to send a thank you card to whomever referred you.

**Client Information***
Complete one of these forms for yourself. Additional persons are to complete their own forms.

**Informed Consent for Use of Email***
Please read through this form then sign and date. If you do not use email, please let your therapist know. You do not need to fill out the form if you do not use email.

**Fee Agreement (two copies – one for you and one for Samaritan)***
You may have clarified your fee with your therapist via phone prior to this session, or it may be set at the first session. Please read and sign at the bottom of both copies. Each additional person is to do the same. **Note:** If you do not plan to use insurance, write your initials in the space provided on both copies. Each additional person is to do the same. Your therapist will sign and return your copy.

**Insurance Information (two sides)**
If you have insurance that you hope will help cover the cost of our service, please fill out the Insurance Information form, front and back, and sign it twice, in the two spaces provided. If you are meeting your therapist in our Main Office, ask the support staff to make and hand you a photocopy, front and back, of your insurance card for you to add to this packet. Although the information requested on the Insurance form appears redundant to what is on your insurance card, it is important that you complete the form entirely. If you are unsure about how to complete the Insurance form, ask your therapist to assist you during your appointment.

**Notice of Privacy Practices (one copy for you)**
You may read this now or later after your first session. Please keep it for your records.

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**Disclosure Statement (two copies – one for you and one for Samaritan)***
At SamaritanPS.org, on the therapist's profile page, download this form separately as it is unique to each therapist. Please read it, print your name in the space for 'client name,' then sign and date once above and below where indicated on the last page. Each additional person must also read and double-sign the last page. Repeat this for the second copy. Your therapist will sign and return your copy.

**After you complete this packet, please keep it in your possession and hand it to your therapist when s/he meets you.**

Thank You.

Samaritan Center

Samaritan
Center of Puget Sound

# CLIENT REFERRAL INFORMATION

For Confidential Use Only

*Thank you for choosing Samaritan Center of Puget Sound.*

Name (s) _____ Today's Date _____

Are you a returning client? ☐ Yes ☐ No

Type of Counseling you are seeking:

Individual _____ Relationship (or Couple) _____ Child _____ Family _____

Age of Primary Client (*please check one*)

- ☐ Under 13 years
- ☐ 13-18 years
- ☐ 19-64 years
- ☐ 65 + years

---

Did you come because you had a specific therapist in mind? ☐ Yes ☐ No Name of therapist_____

If so, is the therapist on your insurance provider list? ☐ Yes ☐ No ☐ Don't Know

How were you referred to the counselor/agency? (*please include name – optional*)

- ☐ Friend _____
- ☐ Relative _____
- ☐ Medical Professional _____
- ☐ Clergy _____
- ☐ Web Search _____
- ☐ Insurance Company _____
- ☐ Other _____

May we contact them to thank them? ☐ Yes ☐ No

Contact Address/Information: _____

_____

_____

_____

*We appreciate your help to make our services more widely accessible.*

Samaritan
Center of Puget Sound

# CLIENT INFORMATION

Chart #_____

For Confidential Use Only

Legal Name_____ Today's Date _____

Address_____
Street Address Apartment #

_____
City State Zip Code

Home Phone_____ Work Phone _____ Cell Phone _____
Leave Message? ☐ Yes ☐ No Leave Message? ☐ Yes ☐ No Leave Message? ☐ Yes ☐ No

E-Mail Address_____ Birthdate_____ Age_____

Emergency Contact _____
Name and phone number

Occupation_____ Employer/School_____

Number of years (or highest level of) education _____

Gender _____ Relationship (or Couple) Status _____ Race/Ethnicity_____

Name/Address of financially responsible party if other than client *(For minors or anyone using 3rd party, non-insurance payor.)*

_____

If client is a minor, name/address/phone of custodial parent, if different from name above_____

_____

Gross annual family income $_____ per year Number dependent on this income _____

Family and household members (includes housemates, spouse, partner and all children *(Continue on back if needed.)*
Clarify if client is a minor from two households *(Include any different last names.)*

| Name | Age | Gender | Relationship | Living with you? |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | ☐ Yes ☐ No |
| _____ | _____ | _____ | _____ | ☐ Yes ☐ No |
| _____ | _____ | _____ | _____ | ☐ Yes ☐ No |
| _____ | _____ | _____ | _____ | ☐ Yes ☐ No |
| _____ | _____ | _____ | _____ | ☐ Yes ☐ No |

Religion _____ Place of worship_____

Is it important for you to have spirituality included in your therapy? ☐ Yes ☐ No

PLEASE CONTINUE ON PAGE 2

Samaritan Copy

Samaritan
Center of Puget Sound

**CLIENT INFORMATION** Chart #_____
For Confidential Use Only

Physician's Name _____Phone _____ Date of last exam_____

Physician's Address_____

It is our practice to coordinate care with the client's physician when this would be helpful. If you agree that we may contact your physician, please check here: ☐ *(Please sign a release of information with your therapist for this purpose.)*

List any surgeries or illnesses you have had the past five years_____

_____

_____

List any medications, including the amount that you currently take or have taken in the past 3 months:

| **Medication** | **Dosage** | **Purpose** | **Start Date** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

What is your purpose in coming to Samaritan at this time?_____

_____

_____

Have you done previous counseling/therapy? ☐ Yes ☐ No If yes, when?_____

Name of Previous Therapist(s) _____ Purpose/issues at that time_____

_____

Do you want to be added to our mailing list for e-newsletters and/or print newsletters? ☐ Yes ☐ No

**FOR THERAPIST'S USE**

**Therapist:**_____ **Office:**_____ **Fee (90791):** _____ **Fee (90834/47):** _____ **Date:** _____

**Payment:** ☐ Ins***** ☐ Samaritan Fund (requires therapist's application) ☐ EAP ☐ 3rd Party Non-insurance Guarantor (i.e., church) ☐ Self-pay

***** Insurance Information form must be completed, double-signed by client, stapled to photocopy of medical card, included with intake paperwork.
☐ Check if insurance paperwork and/or photocopy of medical card is not included and will be submitted later.

**File:** ☐ Individual ☐ Couple ☐ Family (Number of family members _____ ) ☐ Group ☐ Child/Adolescent

If Couple or Family, check one: ☐ **Primary client** ('patient' for insurance purposes; contact for scheduling) ☐ **Additional client(s)**

Client Copy

Samaritan Center of Puget Sound

# CLIENT INFORMATION

For Confidential Use Only

Chart #_____

Legal Name_____ Today's Date _____

Address_____
Street Address Apartment #

_____
City State Zip Code

Home Phone_____ Work Phone _____ Cell Phone _____
Leave Message? ☐ Yes ☐ No Leave Message? ☐ Yes ☐ No Leave Message? ☐ Yes ☐ No

E-Mail Address_____ Birthdate_____ Age_____

Emergency Contact _____
Name and phone number

Occupation_____ Employer/School_____

Number of years (or highest level of) education _____

Gender _____ Relationship (or Couple) Status _____ Race/Ethnicity_____

Name/Address of financially responsible party if other than client *(For minors or anyone using 3rd party, non-insurance payor.)*

_____

If client is a minor, name/address/phone of custodial parent, if different from name above_____

_____

Gross annual family income $_____ per year Number dependent on this income _____

Family and household members (includes housemates, spouse, partner and all children *(Continue on back if needed.)*
Clarify if client is a minor from two households *(Include any different last names.)*

| Name | Age | Gender | Relationship | Living with you? |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | ☐ Yes ☐ No |
| _____ | _____ | _____ | _____ | ☐ Yes ☐ No |
| _____ | _____ | _____ | _____ | ☐ Yes ☐ No |
| _____ | _____ | _____ | _____ | ☐ Yes ☐ No |
| _____ | _____ | _____ | _____ | ☐ Yes ☐ No |

Religion _____ Place of worship_____

Is it important for you to have spirituality included in your therapy? ☐ Yes ☐ No

PLEASE CONTINUE ON PAGE 2

Client Copy

Samaritan
Center of Puget Sound

**CLIENT INFORMATION** Chart #_____
For Confidential Use Only

Physician's Name _____Phone _____ Date of last exam_____

Physician's Address_____

It is our practice to coordinate care with the client's physician when this would be helpful. If you agree that we may contact your physician, please check here: ☐ *(Please sign a release of information with your therapist for this purpose.)*

List any surgeries or illnesses you have had the past five years_____

_____

_____

List any medications, including the amount that you currently take or have taken in the past 3 months:

| **Medication** | **Dosage** | **Purpose** | **Start Date** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

What is your purpose in coming to Samaritan at this time?_____

_____

_____

Have you done previous counseling/therapy? ☐ Yes ☐ No If yes, when?_____

Name of Previous Therapist(s) _____ Purpose/issues at that time_____

_____

Do you want to be added to our mailing list for e-newsletters and/or print newsletters? ☐ Yes ☐ No

**FOR THERAPIST'S USE**

**Therapist:**_____ **Office:**_____ **Fee (90791):** _____ **Fee (90834/47):** _____ **Date:** _____

**Payment:** ☐ Ins***** ☐ Samaritan Fund (requires therapist's application) ☐ EAP ☐ 3rd Party Non-insurance Guarantor (i.e., church) ☐ Self-pay

***** Insurance Information form must be completed, double-signed by client, stapled to photocopy of medical card, included with intake paperwork.
☐ Check if insurance paperwork and/or photocopy of medical card is not included and will be submitted later.

**File:** ☐ Individual ☐ Couple ☐ Family (Number of family members _____ ) ☐ Group ☐ Child/Adolescent

If Couple or Family, check one: ☐ **Primary client** ('patient' for insurance purposes; contact for scheduling) ☐ **Additional client(s)**

Samaritan
Center of Puget Sound

# Informed Consent for the Use of Email

Samaritan clients who wish to communicate with their therapist and/or administrative staff using email are welcome to do so. However, there are a number of privacy concerns and potential risk factors that should be considered before transmitting confidential information by email.

General concerns include: email is immediately broadcast worldwide and can be received by unintended recipients; email messages can be forwarded without the sender's or intended recipient's permission or knowledge; email can easily be misaddressed; back-up copies of emails may exist after the sender or the recipient has deleted them; and email is easier to falsify than documents that are signed and sent by regular mail.

Privacy concerns related to a one's personal health information also need to be considered. It is the policy of Samaritan to make all email messages concerning diagnosis and/or treatment part of that client's medical record and to treat these with the same degree of confidentiality as other portions of the medical record. (Please see your therapist's disclosure statement for details.) Samaritan takes all reasonable means to protect clients' confidentiality but cannot guarantee the security and confidentiality of email communication. Please read the following information outlining Samaritan's conditions for the use of email.

- Samaritan Center of Puget Sound cannot guarantee that electronic communications will be private. Samaritan takes reasonable steps to protect confidentiality but is not liable for improper disclosure of confidential information not caused by negligence or misconduct.

- If the client chooses to use email, the client is responsible for informing Samaritan of any limitations to the kind of information that will be sent by email.

- The client is responsible for protection of their own password or other means of access to email sent or received. Samaritan is not liable for breaches of confidentiality caused by the client.

- Because employees do not have a right of privacy in their employer's email system, clients should not use their work/business system to send or receive confidential medical information.

- When an email is received by a Samaritan therapist or administrative staff person, there will be an attempt made to read it promptly and, when appropriate, respond. However, Samaritan cannot assure a specific time frame and suggests sending a follow-up email or phone call if some time has passed.

- Emails concerning diagnosis and/or treatment become part of the client's medical record and is available to certain authorized entities such as health care providers and insurers for the purposes of treatment and reimbursement. While emails may be forwarded within the agency for these purposes,

Samaritan will not forward the email outside the agency without the consent of the client or as required by law (per your therapist's disclosure statement).

- **Email should not be used when transmitting sensitive medical information.**
- **Email should not be used in the case of a medical emergency.**

I have read the above privacy concerns and conditions for the use of email and consent to the use of email for communications to and from Samaritan Center of Puget Sound.

_____ _____

Signature of Client Date of Signature

_____

Printed Name of Client

Samaritan
Center of Puget Sound

# Individual Counseling Fee Agreement
# Psychologist Level Therapist

**Appointments:**

We are pleased that you have chosen Samaritan Center for your counseling. Counseling sessions include the time used for scheduling and payment. When you need to cancel or reschedule an appointment, please give us at least 24 hours notice. Because your therapist has committed that specific time to your session, our policy is to charge the full fee for late cancellations or missed appointments. Insurance does not reimburse for missed appointments.

**Samaritan Fee Policies:**

Payment is due at each session. Please make your check payable to Samaritan Center. If your account becomes two sessions past due, our policy is to not schedule additional appointments until payments are current or an installment plan is arranged.

During the course of your counseling, if you need additional services for such things as extended sessions, phone consultations, reports, correspondence or the copying of records, we will prorate charges for these services.

For those with financial need, we try to arrive at an adjusted fee. Our ability to adjust fees depends on the resources available to Samaritan.

By signing this document, you agree to pay all charges for services received. If you use insurance to cover some or all of your counseling at Samaritan Center, you agree to pay any amount that your insurance carrier does not pay. This may include, but is not limited to services and charges determined by your insurance carrier not to be medically necessary, and/or services and charges not covered by your insurance plan.

**Samaritan Fees:**
The standard fees for an individual counseling session are:

| | |
|---|---|
| Diagnostic Evaluation Fee: | $230.00 |
| 45-minutes | $155.00 |
| 60-minutes | $205.00 |
| Other_____ | $_____ |
| _____ | $_____ |

*My initials here _____ indicate I do not plan to use insurance.*

*I have read, understand, and agree to the above.*

Client(s) Signature _____ Date _____

_____

Therapist Signature _____

Samaritan
Center of Puget Sound

# Individual Counseling Fee Agreement
# Psychologist Level Therapist

**Appointments:**

We are pleased that you have chosen Samaritan Center for your counseling. Counseling sessions include the time used for scheduling and payment. When you need to cancel or reschedule an appointment, please give us at least 24 hours notice. Because your therapist has committed that specific time to your session, our policy is to charge the full fee for late cancellations or missed appointments. Insurance does not reimburse for missed appointments.

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By signing this document, you agree to pay all charges for services received. If you use insurance to cover some or all of your counseling at Samaritan Center, you agree to pay any amount that your insurance carrier does not pay. This may include, but is not limited to services and charges determined by your insurance carrier not to be medically necessary, and/or services and charges not covered by your insurance plan.

**Samaritan Fees:**
The standard fees for an individual counseling session are:

| | |
|---|---|
| Diagnostic Evaluation Fee: | $230.00 |
| 45-minutes | $155.00 |
| 60-minutes | $205.00 |
| Other_____ | $_____ |
| _____ | $_____ |

*My initials here _____ indicate I do not plan to use insurance.*

*I have read, understand, and agree to the above.*

Client(s) Signature _____ Date _____

_____

Therapist Signature _____

Samaritan
Center of Puget Sound
formerly Presbyterian Counseling Service



# INSURANCE INFORMATION

**Client:** First Name_____M.I._____Last Name_____

Social Security # _____-_____-_____ Birth Date _____________ Gender: M ☐ F ☐
*(Medicare, Tricare, and United Healthcare only)*
Marital Status: Single ☐ Married ☐ Other ☐

Employment Status: Employed ☐ Full-Time Student ☐ Part-Time Student ☐

If there is a specific injury or illness which precipitated coming for counseling: _____

Is patient's Condition Related to: Employment ☐ Auto Accident ☐ Other Accident ☐

State in which occurred _____

Date of current injury or illness ______________ Date of same or similiar condition ___________

Work lost due to current condition from _______________ to _______________

Hospitalization due to current condition from _______________ to _______________

***Client or Authorized Person's Signature:***

***I authorize payment of medical benefits to Samaritan Center of Puget Sound..***
***Signed*_____ *Date*_____

***I authorize the release of any medical or other information necessary to process this claim or any further claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.***
***Signed*_____ *Date*_____

***To be completed by therapist***

Therapist:_____ Provider Number:_____
Prior authorization number (if required):_____
Diagnosis: _____ _____ _____
CPT (Procedure) Codes:_____
In which office will this client be seen? _____

**FOR OFFICE USE ONLY:**

**Insurance carrier:**

**Coverage**:
$_____Client Co-Pay
_____% Client
_____% Payment
$_____Deductible ☐ Met
$_____Remaining
_____ # of Sessions ____ # Remaining
**Policy Effective and End Date**:_____
**Referral:** ☐ None Needed ☐ P.C. Physician
**Comments**:
_____
_____
_____

**Authorization:**
☐ None ☐Regence ☐ Value-Options ☐ UBH
Other _____
Authorization #:_____
# of Sessions Auth. _____
Authorization Date From: _____
☐ Fee Schedule Unavailable

| Code | Allowed | % Amt | Code | Allowed | % Amt |
|---|---|---|---|---|---|
| ☐ 90791 | $_____/ | _____ | ☐ 90832 | $_____/ | _____ |
| ☐ 90834 | $_____/ | _____ | ☐ 90837 | $_____/ | _____ |
| ☐ 90847 | $_____/ | _____ | ☐ 90846 | $_____/ | _____ |

**Comments**:
_____
_____
_____

## Insurance Information - Page 2

**Client Name: _____**

### Insurance Company Information -- Primary Coverage

First Name_____M.I._____Last Name_____

Address_____

City_____ State_____ Zip_____

Home phone_____ Work phone_____

**Policy Holder Information** *(complete section below **IF** policy holder is not client - **OR** - copy of card is not present)* :

Birth Date _______________ Gender: M ☐ F ☐

Client relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Under employer's health plan? *Circle one* Y N Insured's Social Security # _____ - _____ - _____

Employer Name_____

Ins Co. Name_____ Phone number _____

Address_____

City_____ State_____ Zip_____

ID number _____ Group number_____

### Insurance Company Information -- Secondary Coverage

If there is another health benefit plan, complete the following.

**Other Insured Information:**

First Name_____M. I._____ Last Name_____

Birth Date _______________ Gender: M ☐ F ☐

Client relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Under employer's health plan? *Circle one* Y N Insured's Social Security # _____ - _____ - _____

Employer Name_____

Ins Co. Name_____ Phone number _____

Address_____

City_____ State_____ Zip_____

ID number _____ Group number_____

Samaritan
Center of Puget Sound
formerly Presbyterian Counseling Service

# 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.

We have a legal responsibility under the laws of the United States and the state of Washington to keep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice.

This notice takes effect on March 26, 2013 and will be in effect until we replace it.

We have the right to change any of these privacy practices as long as those changes are permitted or required by law.

Any changes in our privacy practices will affect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at Samaritan Center of Puget Sound. These changes could also affect how we protect the privacy of any of your health information we had before the changes.

When we make any of these changes, we will also change this notice and give you a copy of the new notice. When you are finished reading this notice, you may request a copy of it at no charge to you.

If you request a copy of this notice at any time in the future, we will give you a copy at no charge to you.

If you have any questions or concerns about the material in this document, please ask us for assistance which we will provide at no additional charge to you.

Here are some examples of how we use and disclose information about your health information.

**Section I:** Permissible uses and disclosures without your written authorization.

We may use or disclose your health information without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. To your physician or other healthcare provider who is also treating you.
2. To anyone on our staff involved in your treatment program.
3. To any person required by federal, state, or local laws to have lawful access to your treatment program.
4. To receive payment from a third party payer for services we provide for you.
5. To our own staff in connection with our Center's operations. Examples of these include, but are not limited to the following: evaluating the effectiveness of our staff, supervising our staff, improving the quality of our services, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities.
6. To a family member, a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object.

If you object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects your health information that are necessary to respond to the emergency.

7. When required or permitted to do so by law. For example, to appropriate authorities if your therapist reasonably believes that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access your health information; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law
8. We will not use your health information in any of our Center's marketing, development, public relations, or related activities without your written authorization. We cannot use or disclose your health information in any ways other than those described in this notice unless you give us written permission.

**Section II**

**With written permission:** We may use or disclose your health information to anyone you give us written authorization to have your health information, for any reason you want. You may revoke this authorization in writing anytime you want. When you revoke an authorization it will only effect your health information from that point on.

**Psychotherapy Notes:** Notes recorded by your therapist documenting the contents of a counseling session with you ("Psychotherapy Notes") are not part of your health information. They will be used only by your therapist and will not otherwise be used or disclosed without your written authorization.

As a client of Samaritan Center of Puget Sound, **you have these important rights:**

A. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for our use.

B. You can ask us for photocopies of the information in part "A" above.

C. You will be charged a fee for making these photocopies, based on the total number of pages. For more information about the current price per page, contact the Samaritan front office.

D. You have a right to a copy of this notice at no charge.

E. You can make a written request to have us communicate with you about your health information by alternative means, at an alternative location. (An example would be if your primary language is not spoken at this Center, and we are treating a child of whom you have lawful custody.) Your written request must specify the alternative means and location.

F. You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those which, in our professional judgment, constitute an emergency.

G. You can make a written request that we amend the information in part "A" above.

H. If we approve your written amendment, we will change our records accordingly. We will also notify anyone else who may have received this information, and anyone else of your choosing.

I. If we deny your amendment, you can place a written statement in our records disagreeing with our denial of your request.

J. You may make a written request that we provide you with a list of those occasions where we or our business associates disclosed your health information for purposes other than treatment, payment, or our Center's operations. This can go back as far as six years, but not before April 14, 2003.

K. If you request the accounting in "J" above more than once in a 12 month period we may charge you a fee based on our actual costs of tabulating these disclosures.

L. If you believe we have violated any of your privacy rights, or you disagree with a decision we have made about any of your rights in this notice you may complain to us in writing to the following person:

| **HIPAA Security Officer:** | **Address** |
|---|---|
| **Matthew Percy, Psy.D.**<br>**Telephone: (206) 527-2266**<br>**Fax: (206) 527-1009**<br>**E-mail: mpercy@samaritanps.org** | **Samaritan Center of Puget Sound**<br>**564 NE Ravenna Blvd.**<br>**Seattle, WA 98115** |

M. You may also submit a written complaint to the United States Department of Health and Human Services. We will provide you with that address upon written request.

Samaritan
Center of Puget Sound
formerly Presbyterian Counseling Service

# Terms Important in Understanding the HIPAA Privacy Rule

**Health Information:**

Any information, whether oral or recorded in any form, created or used by health care professionals or health care entities.

Individually Identifiable Health Information: A subset of Health Information that either identifies the individual or that can be used to identify the individual.

**Protected Health Information (PHI)**

Individually Identifiable Health Information becomes Protected Health Information when it is transmitted or maintained in any form or medium. More specifically, PHI is information that relates to the past, present or future physical or mental health condition of an individual; or the past, present or future payment for the provision of health care to individual; and that identifies the individual or could reasonably be used to identify the individual.

**Psychotherapy Notes**

Notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or group, joint or family counseling session, and that are separated from the rest of the individual's medical record.

**Use and Disclosure**

The privacy rule defines "use" as the sharing, employment, application, utilization, examination or analysis of individually identifiable health information within an entity that maintains such information.

The privacy rule defines a "disclosure" as the release, transfer, provision or access to, or divulging in nay other manner of information outside the entity holding the information.

The definition of the privacy rule specifically excludes information pertaining to medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following: diagnosis, functional status, the treatment plan, symptoms, prognosis and process to date.