Thank you for choosing our center.

We thank you for choosing the Child & Family Guidance Center of Texoma for you and your family's mental health and wellness needs. Mental healthcare is most successful when clear expectations are outlined initially to promote an ideal provider-client relationship. Below are expectations that will promote this relationship.

What You Can Expect From Us

- All CFGC staff will be welcoming, patient, kind and knowledgeable.
- To be treated with compassion, respect and dignity.
- Nonjudgmental environment
- To protect and respect your privacy.
- To maintain the highest level of confidentiality.
- Clinicians strive to make each client feel as though you are their only client.
- Clinician will partner with clients in treatment decision making.
- Your time is respected. Sessions start and end on time.
- We strive to return phone calls/communicate with you promptly.
- We are thankful to you for choosing CFGC for you/your family's mental healthcare needs.

What We Need From You

- To show kindness, courtesy and respect to others at CFGC. This includes supervising children in your care while at the center.
- To arrive on time for your scheduled appointments.
- Be patient and understanding with office procedures- scheduling times, legal requirements, etc.
- To notify CFGC as soon as you are aware that you are unable to keep a scheduled appointment. This allows us to help others when you are not here.
- Inform our office of any pertinent changes – contact information, health issues, other providers, insurance information.
- Only use cell phones outside the building -showing respect and regard to others.
- Provide payment for services provided.
- Follow the agreed upon treatment plan and inform your clinician of any changes.
- Share questions or concerns with your clinician or other staff to ensure the best possible care.

We Value

Our Commitment to Transparency: **honesty, integrity, and fairness**

Our Clients: **why we exist**

Our Community: **every relationship maters**

Mission

The Child & Family Guidance Center of Texoma exists to strengthen, improve, and empower the lives of hurting Texoma children and families, through compassionate and restorative mental healthcare.

Vision

To be a leading trauma informed care mental health resource throughout the Texoma community by providing innovative treatment, prevention and intervention programs, internships, community education, and collaborative partnerships.

Values

The Child & Family Guidance Center of Texoma embraces an environment that values transparency, the resilience and dignity of people served, and the community's passionate support of our mission.

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Consent to Treatment, Communication & Financial Responsibility

PLEASE READ AND INITIAL ALL ELEVEN (11) STATEMENTS BELOW

I. I certify that I have the LEGAL AUTHORITY to authorize and consent for *NAME OF CLIENT(S)* _____to receive treatment/evaluation at Child & Family Guidance Center of Texoma. If applicable, I consent to present a copy of my divorce decree and/or custody document(s), etc., certifying my legal authority to seek psychological services for the named client.
Initials: _____

II. I understand that determination for treatment, if any, will be made by Child & Family Guidance Center of Texoma. Also, I understand that any such recommendations will be explained, and that I have the option to accept or reject the recommendations.
Initials: _____

III. I agree to pay for the cost of psychological services provided at the time of service.
Initials: _____

IV. I authorize payment of medical benefits to the named provider for professional services rendered, and I authorize release of any related information necessary for my treatment and for the filing of insurance.
Initials: _____

V. I understand that unless a verifiable emergency exists, I must cancel or re-schedule my appointment 24 hours in advance.
Initials: _____

VI. I acknowledge I have read, understood, consent to, and agree to comply with the CFCG Client Service Agreement and CFCG Confidentiality Statement.
Initials: _____

VII. I hereby consent to the use or disclosure of Protected Health Information of the named client(s) for treatment, payment, and health care operations. Please list any restrictions of the named client's mental/medical record that you do not want to disclose:_____
Initials: _____

VIII. I acknowledge I have access to CFGC's HIPAA Notice of Privacy Practices, Office Policies & General Information Agreement for Psychotherapy Services (copies in waiting room or at www.cfgcenter.org).
Initials: _____

IX. If needed, I authorize the CFGC clinician involved in the treatment of myself and/or my child to contact me to discuss confidential information by calling from a landline/CELL PHONE to:
Home phone: ◉ Yes ○ No Cell phone: ◉ Yes ○ No Work phone: ◉ Yes ○ No
Initials: _____

X. I authorize CFGC staff to leave messages via my answering machine/voicemail, text or email for appointments, reminders, general mental health information, billing, and/or referral information.
Initials: _____

XI. Authorization is valid until rescinded by me in writing.
Initials: _____

Parent/Guardian/Client/Signature:_____Date:_____
Your signature confirms your understanding and agreement to adhere to the above statements.

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Court Services, Records, & Correspondence Agreement

I/We hereby understand and agree to the following requirement and charges that I/We may incur if a clinician or any other CFGC staff is involved in a court case or related matter on behalf of myself, my spouse, my children, or my family. I/We understand that these terms are applicable both while I/We are receiving services, as well as following termination. I/We understand that if I or a family member is a victim of a crime that I/We may be eligible for the following fees to be covered by the Texas Crime Victims' Compensation.

COURT ORDERED SERVICES AND CORRESPONDENCE/RECORDS REQUESTS:
A signed copy of the court order or CPS Service Plan must be received by CFGC BEFORE services can be scheduled. Once the order/service plan has been reviewed by the Clinical Director, services will be scheduled per the court order/service plan if CFGC can offer services which will comply with the order.

Fees for Court/Attorney Related Services: ALL FEES FOR COURT TESTIMONY, CORRESPONDENCE AND/OR RECORDS MUST BE PAID IN ADVANCE. COUNSELING SERVICES MUST BE PAID AT TIME OF SERVICE.

1. Phone Consultations with Attorneys, Mediators, Family Court Counselors, District Attorneys:
$100 per phone consultation up to 45 minutes.

2. Reports and/or client summary for court, attorneys:
$100.00 per report.

3. Court deposition or court testimony in civil cases:
$500.00 non-refundable, minimum charge for first required appearance up to 4hours, regardless of actual time spent in court. Any additional dates or hours of appearance within a year of initial court appearance payment will require payment of $150.00/ PER HOUR. After a year, fees start over at $500 for the first 4 hours and $150 for each additional hour. If court is canceled or rescheduled without 24hour notice given, the fee still applies and is nonrefundable. Any out-of-COUNTY charges must be reimbursed as above and will include actual out-of-pocket travel expenses, to include mileage and/or transportation costs, tolls, parking fees, meals, and lodging (Based on current IRS mileage rate). By law, if a county is more than 150 miles from where a therapist resides or is served, the therapist is NOT required by subpoena to appear or produce documents. Pre-payment is required.

Requirements

1. Release: For those cases referred by the court system, clients MUST sign release of information forms allowing CFGC clinicians to openly communicate with all parties related to the suit. To ensure safety and professionalism of the counseling process, NO exceptions will be given.

2. Subpoena: A subpoena must be issued before the clinician or any other agency personnel can make a court appearance, deposition appearance, or deliver any records. We request 48 business hours notice before the court date be given in order for the therapist to properly prepare. Party issuing subpoena will be financially responsible for ALL related fees. If therapist is subpoenaed by both parties each party will be responsible for the $500 fee to appear.

3. Fee for Civil Cases If subpoena is delivered for a civil case the process server MUST bring $10.00 to recipient of subpoena. Does not apply in criminal cases.

4. Information for parent/guardian and copies of client records: *NOT COURT RELATED
Per Texas Administrative Code 165.2 copy fees are: $25.00 for the first 20 pages, plus $0.50 for each additional page.
Per Texas Administrative Code 165.2 CFGC has 15 business days after receiving the request to provide the records.

5. Counseling Fees: Fees must be paid at time of service.
Intake session $130.00 Regular Session $100.00-$125.00
All other court ordered services fees are set according to service requested.

6. Completion of disability paperwork: Client must be seen for at least six (6) sessions before paperwork for disability can be completed. A charge of $15 will be incurred for completing the paperwork and must be paid BEFORE completed paperwork is released.

7. Phone conversations with therapist: Counseling sessions can be conducted by phone and will be billed at the regular rate. If an emergency exists, the clients can speak BRIEFLY to their therapist by phone. If the call last longer than 16 minutes, a session will be billed to the insurance or client.
NOTE: SLIDING SCALE FEES DO NOT APPLY TO COURT ORDERED SERVICES.

I acknowledge I have read, understand, consent to, and agree to comply with the CFCG Court Services, Records & Correspondence Client Service Agreement.

Parent/Guardian/Client/Signature:_____**Date:**_____

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Client Demographic and Payment Information

Client Information

1. Client's First Name:_____ Last Name:_____ MI:_____
   Date of Birth: _____ Age:_____ Gender: _____ Ethnicity:_____
2. Client's First Name:_____ Last Name:_____ MI:_____
   Date of Birth: _____ Age:_____ Gender: _____ Ethnicity:_____
3. Client's First Name:_____ Last Name:_____ MI:_____
   Date of Birth: _____ Age:_____ Gender: _____ Ethnicity:_____
4. Client's First Name:_____ Last Name:_____ MI:_____
   Date of Birth: _____ Age:_____ Gender: _____ Ethnicity:_____
5. Client's First Name:_____ Last Name:_____ MI:_____
   Date of Birth: _____ Age:_____ Gender: _____ Ethnicity:_____

Responsible Party/Contact Information

Parent/Guardian/Adult Client:_____ DOB: ___/___/_____
Address:_____ City:_____ St:_____Zip:_____
Phone number(s):_____ E-mail:_____
OK to call or leave message? ____Yes ____ No Referred by:_____

If address of client is different please provide:
Address:_____City:_____ St:_____Zip:_____

- **If you are divorced or obtain legal guardianship, you must show legal proof (divorce decree and/or custody documents) before treatment can begin.**
- **Are you court ordered to receive counseling services? ____ Yes ____ No**
- **Is CPS involved in any way with you or your family? ____ Yes ____ No**
- **Does the client have insurance? ____ Yes ____ No Type:_____**
  Policy #:_____ Phone #: _____

Uninsured clients are eligible for sliding scale fees

If you do not have insurance, a sliding scale fee is available to assist those who are unable to pay the full amount for services. The sliding scale program is based on total household net income and family size. A copy of your most recent pay stub, income tax return, W-2, and/or 1099 of all adults living in the household as well as any child support, unemployment or disability income is required for proof of income.

To qualify, please complete the following and provide proof at your initial appointment.

Name:_____ Relationship to client:_____ Annual Income:_____
Name:_____ Relationship to client:_____ Annual Income:_____
Total # of People living in household?_____ Total NET household income:_____

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Current Concerns and Client History
Ages 3-17

Client Name: _____ Age: ____ Gender: _____
Ethnicity: _____ Phone #: _____

Presenting Problem:
Describe the problem(s) you and/or your child are having and when they began: _____
_____
_____

What do you believe has contributed to the problem(s)? _____
_____
_____

CURRENT CONCERNS: Please check all that apply and place a star next to the items of significant concern.

Mood Related Issues
- ☐ Anger
- ☐ Disturbing memories
- ☐ Difficulty going to sleep/staying asleep
- ☐ Nightmares/night terrors
- ☐ Suicidal thinking or talking
- ☐ Irritability
- ☐ Sadness/Depression
- ☐ Feelings of guilt and shame
- ☐ Excessive worrying/fear/anxiety
- ☐ Other (please specify) _____

_____
_____
_____

Behavioral/Conduct Issues
- ☐ Anger issues
- ☐ Aggression toward others
- ☐ Drug/Alcohol use
- ☐ Truancy
- ☐ Gang involvement
- ☐ Running away
- ☐ Stealing
- ☐ Intentionally hurting animals
- ☐ Fire-setting
- ☐ Other unusual behaviors

(please specify) _____
_____
_____

Family Relationship Issues
- ☐ Divorce
- ☐ Difficulty adjusting to family changes
- ☐ Discipline concerns
- ☐ Parent-Child relationship problems
- ☐ Sibling concerns
- ☐ Divorce/Separation
- ☐ Religious/Spiritual concerns
- ☐ Constant fighting
- ☐ Other (please specify) _____

_____
_____
_____

Other Behavioral Concerns
- ☐ Sexual identity concerns
- ☐ Inappropriate sexual behavior
- ☐ Overeating/Refusal to eat
- ☐ Bedwetting or soiling
- ☐ Hyperactive/Impulsivity
- ☐ Inattentive
- ☐ Lying
- ☐ Oppositional/Defiant
- ☐ Grief/Loss
- ☐ Medical problems (please specify)

_____
_____

Other (please specify) _____
_____
_____

Work/School Issues
- ☐ Learning difficulties
- ☐ Problems with peers
- ☐ Problems with teachers
- ☐ Failing grades
- ☐ Refusing to go to school
- ☐ Peer/friend problems at school
- ☐ Other (please specify) _____

_____
_____
_____

Treatment History:

1. Past or present counseling services received? ☐ No ☐ Yes When?_____
   Provider Name: _____ How long? _____
   Did treatment help you? ☐ No ☐ Yes
2. Past psychological evaluation: ☐ No ☐ Yes (Please provide a copy of evaluation if possible.)
3. Past hospitalizations for emotional/behavioral issues or alcohol/drug treatment? ☐ No ☐ Yes
   When/Where: _____
4. Is there a history of mental health issues in your family? ☐ No ☐ Yes
   Please list family members: _____

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Current Concerns and Client History
Ages 3-17

Client Name:_____

Family History:

1. Who do you live with now?☐ Both parents ☐ Mother ☐ Father ☐ Other relative ☐ Other
2. Do you have siblings? ◯ No ◯ Yes ☐ Brothers/Sisters ☐ Step or Half Brothers/Sisters
   How many? _____ Ages: _____
3. Do you live with your siblings now? ◯ No ◯ Yes
4. Do you eat dinner together as a family at the table? ◯ No ◯ Yes How many times per week? ____
5. Estimated number of hours per day that you spend watching TV, listening to music, using a computer, on social media, or talking and texting on cell phone: _____
6. Who are some important people in your life? _____
7. Your life experiences growing up can affect your life. What experiences or events (divorce, grief, family violence, discipline, favoritism, trauma, affection, lack of attention, bullying, or others) have made a difference in your life?
   _____
   _____
   _____

Educational History:

1. What grade are you in now? _____
2. Do you have any problems in school? ☐ Academic ☐ Discipline ☐ Friends/Social ☐ Bullying
3. How has your attendance been this school year? ◯ Excellent ◯ Good ◯ Poor
4. How have your grades been this school year? ◯ Excellent ◯ Good ◯ Poor
5. What are your extra-curricular activities? _____
   _____
6. Do you have any learning difficulties or attend special classes? ◯ No ◯ Yes:_____
   _____
   _____
7. If you work, how many hours per week? _____ Job Title: _____

Social History:

1. From whom do you get emotional support? _____
2. Do you have friends? ◯ No ◯ Yes How do you get along with your friends? _____
3. Has there been a change in your circle of friends lately? ◯ No ◯ Yes
4. What have been the losses, changes, crises and transitions in your life? _____
   _____
   _____
5. Do you have a belief system (cultural, moral, spiritual, religious, etc.) which influences your life? _____
   _____
6. Is there anything about your lifestyle (or your family or friends) that would be helpful for your therapist to know? __
   _____
   _____

Medical History:

1. Client's general health is? ◯ Excellent ◯ Good ◯ Fair ◯ Poor
2. List any allergies, serious illnesses, surgeries or injuries, hospitalizations: _____
   _____
3. What physical illnesses run in your family? _____
   _____
4. What is the name of your doctor? _____

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Child Youth Wellness Adverse Childhood Experiences Questionnaire (ACE-Q) Teen Self-Report

To be completed by Patient

Today's Date: ___/___/_____

Your Name: _____ Date of Birth: ___/___/_____

Many children experience stressful life events that can affect their health and development. The results from this questionnaire will assist your counselor in assessing your health and determining guidance. Please read the statements below. Count the number of statements that apply to you and write the total number in the box provided.

Please DO NOT mark or indicate which specific statements apply to you.

1) Of the statements in Section 1, HOW MANY apply to you? Write the total number in the box. ☐

Section 1. *At any point after you were born....*

- Your parents or guardians were separated or divorced.
- You lived with a household member who served time in jail or prison.
- You lived with a household member who was depressed, mentally ill or attempted suicide.
- You saw or heard household members hurt or threaten to hurt each other.
- A household member swore at, insulted, humiliated, or put you down in a way that scared you OR a household member acted in a way that made you afraid that you might be physically hurt.
- Someone touched your private parts or asked you to touch their private parts in a sexual way that was unwanted, against your will, or made you feel uncomfortable.
- More than once, you went without food, clothing, a place to live, or had no one to protect you.
- Someone pushed, grabbed, slapped or threw something at you OR you were hit so hard that you were injured or had marks.
- You lived with someone who had a problem with drinking or using drugs.
- You often felt unsupported, unloved and/or unprotected.

2) Of the statements in Section 2, HOW MANY apply to you? Write the total number in the box. ☐

Section 2. *At any point after you were born....*

- You have been in foster care.
- You have experienced harassment or bullying at school.
- You have lived with a parent or guardian who died.
- You have been separated from your primary caregiver through deportation or immigration.
- You have had a serious medical procedure or life threatening illness.
- You have often seen or heard violence in the neighborhood or in your school neighborhood.
- You have been detained, arrested or incarcerated.
- You have often been treated badly because of race, sexual orientation, place of birth, disability or religion.
- You have experienced verbal or physical abuse or threats from a romantic partner (i.e. boyfriend or girlfriend).

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Patient Health Questionnaire (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns _____ + _____ + _____

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: _____

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

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Generalized Anxiety Disorder 7-item (GAD-7) Scale

Client Name:_____

Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all**	**Several days**	**Over half the days**	**Nearly everyday**
1. Feeling nervous, anxious, or on edge	○ 0	○ 1	○ 2	○ 3
2. Not being able to stop or control worrying	○ 0	○ 1	○ 2	○ 3
3. Worrying too much about different things	○ 0	○ 1	○ 2	○ 3
4. Trouble relaxing	○ 0	○ 1	○ 2	○ 3
5. Being so restless that it's hard to sit still	○ 0	○ 1	○ 2	○ 3
6. Becoming easily annoyed or irritable	○ 0	○ 1	○ 2	○ 3
7. Feeling afraid as if something awful might happen	○ 0	○ 1	○ 2	○ 3
Add the score for each column	____ +	____ +	____ +	____
Total Score *(add your column scores)* =	_____			

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐
Somewhat difficult ☐
Very difficult ☐
Extremely difficult ☐

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med*. 2006;166:1092-1097.

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HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date April 12, 2003, Revised June 2007, March 2010, November 2011, January 2013, January 2020

I. 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.

II. IT IS CFGC'S LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).
By law CFGC is required to ensure that your PHI is kept private. The PHI constitutes information created or noted by CFGC that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. CFGC is required to provide you with this Notice about our privacy procedures. This Notice must explain when, why, and how CFGC would use and/or disclose your PHI. Use of PHI means when CFGC shares, applies, utilizes, examines, or analyzes information within its practice; PHI is disclosed when CFGC releases, transfers, gives, or otherwise reveals it to a third party outside this practice. With some exceptions, CFGC may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, CFGC is always legally required to follow the privacy practices described in this Notice.

Please note that CFGC reserves the right to change the terms of this Notice and its privacy policies at any time. Any changes will apply to PHI already on file with CFGC. Before CFGC makes any important changes to its policies, CFGC will immediately change this Notice and post a new copy of it in the office and on its website. You may also request a copy of this Notice from CFGC or you can view a copy of it in the office or on the website, which is located at www.cfgcenter.org.

III. HOW CFGC WILL USE AND DISCLOSE YOUR PHI
CFGC will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of CFGC's uses and disclosures, with some examples.
A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. CFGC may use and disclose your PHI without your consent for the following reasons:
1. For treatment. CFGC may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, CFGC may disclose your PHI to her/him in order to coordinate your care.
2. For health care operations. CFGC may disclose your PHI to facilitate the efficient and correct operation of center practices. Examples: Quality control - CFGC might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. CFGC may also provide your PHI to its attorneys, accountants, consultants, and others to make sure that CFGC is in compliance with applicable laws.
3. To obtain payment for treatment. CFGC may use and disclose your PHI to bill and collect payment for the treatment and services CFGC provided to you. Example: CFGC might send your PHI to your insurance company or health plan in order to get payment for the health care services that a therapist has provided to you. CFGC could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for our office.
4. Other disclosures. Examples: Your consent is not required if you need emergency treatment, provided that your CFGC therapist attempts to get your consent after treatment is rendered. In the event that CFGC tries to get your consent, but you are unable to communicate with CFGC (for example, if you are unconscious or in severe pain), but CFGC thinks that you would consent to such treatment if you could, CFGC may disclose your PHI.
B. Certain Other Uses and Disclosures Do Not Require Your Consent. CFGC may use and or disclose your PHI without your consent or authorization for the following reasons:
1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or law enforcement. Example: CFGC may make a disclosure to the appropriate officials when a law requires us to

report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. If disclosure is compelled by a party to a proceeding before a court of law and/or administrative agency pursuant to its lawful authority.
3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
4. If disclosure is compelled by the patient or the patient's representative pursuant to Texas Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.
5. To avoid harm. CFGC may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.
6. If disclosure is compelled or permitted by the fact that you are experiencing a mental or emotional condition as to be dangerous to yourself or the person or property of others, and if CFGC determines that disclosure is necessary to prevent the threatened danger.
7. If a disclosure is mandated by the Texas Child Abuse and Neglect Reporting law. For example, if CFGC has a reasonable suspicion of child abuse or neglect.
8. If disclosure is mandated by the Texas Elder/Dependent Adult Abuse Reporting law. For example, if CFGC has a reasonable suspicion of elder abuse or dependent adult abuse.
9. If disclosure is compelled or permitted by the fact that you tell CFGC's therapist of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, CFGC may need to give the county coroner information about you.
11. For health oversight activities. Example: CFGC may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. For specific government functions. Examples: CFGC may disclose PHI of military personnel and veterans under certain circumstances. Also, CFGC may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. For research purposes. In certain circumstances, CFGC may provide PHI in order to conduct medical research.
14. For Workers' Compensation Purposes. CFGC may provide PHI in order to comply with Workers' Compensation laws.
15. Appointment reminders and health related benefits or services. Examples: CFGC may use PHI to provide appointment reminders. CFGC may use PHI to give you information about alternative treatment options or other health care services or benefits we offer.
16. If an arbitrator or arbitration panel compels disclosure. When arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. CFGC is permitted to contact you without your prior authorization to provide appointment reminders or information about alternative or other health-related benefits and services that may be of interest to you.
18. If disclosure is permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess a therapist's compliance with HIPPA regulations.
19. If disclosure is otherwise specifically required by law.
C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.
1. Disclosures to family, friends, or others. CFGC may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.
D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, CFGC will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing,

to stop any future uses and disclosures (assuming that CFGC hasn't taken any action subsequent to the original authorization) of your PHI by CFGC.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in CFGC's possession, or to get copies of it; however, you must request it in writing. If CFGC does not have your PHI, but knows who does, CFGC will advise you how you can get it. You will receive a response from CFGC within 30 days of us receiving your written request. Under certain circumstances, CFGC may feel it must deny your request, but if we do, we will give you, in writing, the reasons for denial. We will also explain your right to have its denial reviewed. If you ask for copies of your PHI, CFGC will charge $25.00 for the first 20 pages and .50 cents for each additional page. This recommended fee is set by Texas State Law. CFGC may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that CFGC limit how we use and disclose your PHI. While CFGC will consider your request, CFGC is not legally bound to agree, IF we do agree to your request, we will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that CFGC is legally required or permitted to make.

C. The Right to Choose How CFGC Sends Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). CFGC is obliged to agree to your request providing that CFGC can give you the PHI, in the format you requested, without undue inconvenience.

D. The Right to Get a List of the Disclosures CFGC Has Made. You are entitled to a list of disclosures of your PHI that CFGC has made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years. CFGC will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list CFGC gives you will include disclosures made in the previous six years (the first six-year period being 2003-2009), unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including the party's address, if known), a description of the information disclosed, and the reason for the disclosure. CFGC will provide the list to you at no cost, unless you make more than one request in the same year, in which case CFGC will charge you a reasonable sum based on a set fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that CFGC correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of CFGC's receipt of your request. CFGC may deny your request, in writing, if CFGC finds that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of CFGC's records, or (d) written by someone other than CFGC. Our denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and CFGC's denial be attached to any future disclosures of your PHI. If CFGC approves your request, we will make the change(s) to your PHI. Additionally, CFGC will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

F. The Right to Get This Notice by Email. You have the right to get this notice by email. You have the right to request a paper copy of it as well.

V.HOW TO COMPLAIN ABOUT CFGC'S PRIVACY PRACTICES

If, in your opinion, CFGC has violated your privacy rights, or if you object to a decision CFGC made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written

complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about CFGC's privacy practices, CFGC will take no retaliatory action against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT CFGC'S PRIVACY PRACTICES

If you have any questions about this notice or any complaints about CFGC's privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact CFGC Executive Director or Clinical Director at 804 E. Pecan Grove Road, Sherman, TX 75090, (903) 893-7768 or bhayward@cfgcenter.org.

Note: CFGC acknowledges that state law may preempt HIPAA regulations IF the state law is more protective of an individual's privacy.