

**Leonard M. Bohanon, PhD**  
**Psychologist**

2203 Timberloch Pl., Suite 100  
The Woodlands, TX 77380

Phone: (832) 628-5253  
Fax: (281) 727-0428  
drbohanon@lmbphd.com

**PERSONAL DATA RECORD**

Client Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

SSN: \_\_\_\_\_ TXDL: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Referred to Our Office by: \_\_\_\_\_

May we send a Thank You card to the person who referred you? (Yes or No)

May we mention your name in that Thank You card? (Yes or No)

**INSURANCE INFORMATION**

Insured Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Client \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's SSN \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Policy No.: \_\_\_\_\_ Group No. \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone \_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address/Phone: \_\_\_\_\_

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

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

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

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

- “*PHI*” refers to information in your health record that could identify you.
- “*Treatment, Payment and Health Care Operations*”  
*Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be consultation with another health care provider, such as your family physician or a colleague.  
*Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer or billing service to obtain reimbursement for your health care or to determine eligibility or coverage.  
*Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “*Use*” applies only to activities within this practice such as utilizing information that identifies you.
- “*Disclosure*” applies to activities outside of this practice, such as releasing, transferring, or providing access to information about you to other parties.

### II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. “*Psychotherapy notes*” are notes we have made about our conversation regarding a private, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

### III. Uses and Disclosures with Neither Consent nor Authorization

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

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Abuse of the Elderly and Disabled:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
- **Sexual Misconduct by a Therapist:** We are required to report any incidents of sexual misconduct by a current or former therapist to the offending therapist’s licensing authority.
- **Regulatory Oversight:** If a complaint is filed against a therapist with a regulatory authority, they have the authority to subpoena confidential mental health information relevant to that complaint.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

#### **IV. Client's Rights and Our Professional Duties**

##### Client's Rights:

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

##### Our Professional Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post a current copy in our offices. A current copy will always be available on our web site and you may request a personal copy.

#### **V. Questions and Complaints**

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Dr. Bohanon at (832) 628-5253.

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to Dr. Bohanon at 2203 Timberloch Pl., Suite 100, The Woodlands, TX 77380.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

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

This notice will go into effect on 7/7/2008. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice on our web site. You may request a personal copy at any time.

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**OFFICE INFORMATION AND OFFICE POLICIES**

I am honored that you have selected me for professional services. All of us at this practice will do our best to assist you in making this experience meaningful and fruitful.

**Psychological Services:** Psychotherapy is not easily described in general terms. It varies depending on the personalities of the therapist and client(s), and the particular problems you are experiencing. There are many different methods we can use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and in between sessions.

Psychotherapy can have benefits and risks. Since therapy sometimes involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. It is important that we discuss any questions, discomfort, or concerns you have regarding the psychotherapy process. We will probably be able to adapt the psychotherapy process to better meet your needs.

**Payment for Services:** We request that clients pay fees or copayments at each session unless other arrangements have been made in advance. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will provide certain forms and provide whatever assistance we can in helping you utilize your benefits. **However, you (not your insurance company) are responsible for full payment of fees.** It is very important that you find out exactly what mental health services your insurance policy covers. **If we are unable to verify your insurance benefits and/or if claims are denied, we reserve the right to bill you for the full cost of your session(s).**

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. We will attempt to provide you with whatever information we can based on our experience and will try to help you understand the information.

My regular fee for clinical services is \$170 per hour for the initial visit and \$160 per hour for each subsequent visit (unless dictated otherwise by a contract with your insurance company, in which case the contract determines the fees, copayments, etc.). We assess a fee of \$15 for returned checks. I do not provide legal testimony services. If compelled to provide those legal testimony services, there are additional fees which are substantially higher than my fees for clinical services.

**Confidentiality:** The law protects the privacy of all communications between a client and psychotherapist. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by federal and state law. There are other situations that require only that you provide written, advance general consent. Your signature on our Acknowledgment form provides consent for those activities, as follows:

You should be aware that we practice with other mental health professionals and utilize administrative professionals. In most cases, some protected information must be shared with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. Occasionally, it is helpful to consult

other health and mental health professionals about a client. During a consultation, every effort is made to avoid revealing a client's identity. Any other professionals consulted are also legally bound to keep the information confidential. These consultations are very commonplace and routine and may not ordinarily be mentioned in our sessions unless it seems important to our work together. If you would prefer to handle this differently, please let me know. All administrative professionals have been given training about protecting your privacy and have agreed not to release any information except as allowed by law and professional ethics.

In some situations we practice Family Therapy. Family Therapy is utilized where two or more family members (sometimes including couples that may not be legally married) are working on the same or related concerns, usually with the same therapist. Family therapy sessions frequently involve two or more people being seen together, but may involve sessions where only some members of the family are present (perhaps only a single member). In these cases, our general practice is to keep information confidential (as discussed in these policies) outside the family, but to share information between family members where that seems both practical and in our professional judgment, is likely to be helpful. If you have any questions about this policy or would prefer the situation be handled differently, please discuss this with me.

Managed Health Care plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. Under these plans, it may be necessary to seek approval for more sessions periodically. You should also be aware that contracts with health insurance companies generally require that we provide them with information relevant to the services you are being provided. We are usually required to provide a clinical diagnosis. Sometimes, additional clinical information such as treatment plans or summaries is also required. In such situations, we make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over its use. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above.

We also have contracts with some business services, such as a billing service, electronic claims processing services, and managed care organizations. As required by federal law, we have formal business associate contracts with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. Details of these contracts are available on request.

**Qualifications:** I am licensed in Texas both as a Psychologist and a Marriage and Family Therapist. I have over 25 years of experience in various psychological practice settings. You are invited to ask any questions you have about my background, experience, etc.

**Emergencies:** If you are in a crisis that cannot wait until your next appointment, you may call on an emergency basis. If I am not immediately available, I will return your call as quickly as possible. If you are unable to wait for me to return your call, please contact either a hospital emergency room, your regular physician, or law enforcement authorities as the situation dictates.

**Appointments:** When you make an appointment, time is reserved for you. Please make every effort to keep and be on time for scheduled appointments. As a professional, I will endeavor to do the same. If you have to cancel an appointment or will be more than a few minutes late, please provide as much notice as you can.

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**Please indicate below how we may contact you and whether we can leave a message:**

Home Phone            May we leave a message (Yes or No)?

Work Phone            May we leave a message (Yes or No)?

Cell Phone            May we leave a message (Yes or No)?

U.S. Regular Mail to home address (if you do not want mail sent to your home, please provide us an alternative address for billing and other correspondence)

Unencrypted (normal) email (address): \_\_\_\_\_

Other (Specify) \_\_\_\_\_

**You may change the above instructions at any time by requesting another one of these forms or otherwise instructing us in writing.**

**ACKNOWLEDGEMENT**

I have been provided a copy of the **Notice of Policies and Practices to Protect the Privacy of Your Health Information** and the **Office Information and Office Policies**. I understand and accept those policies and practices. This practice is hereby granted consent to contact me as specified above, and for the use and disclosure of my health information as described in those policies for Treatment, Payment and Health Care Operations. I hereby consent to evaluation and treatment for myself and/or my dependent(s) specified on the Personal Data Record.

\_\_\_\_\_  
Client or Authorized Representative Signature Date

Refused to Sign

Unable to Sign (Specify Reason) \_\_\_\_\_

\_\_\_\_\_  
Signature of Person Documenting Refusal or Inability to Sign Date