



# Dothan Behavioral Medicine Clinic

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*A Welcome Message From Our Medical Director.*

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Welcome,

On behalf of the staff at the Dothan Behavioral Medicine Clinic, we would like to thank you for making us your choice in advanced behavioral medicine.

We pride ourselves on providing you with the highest quality of care in a private and comfortable setting.

Within this packet, you will find helpful information that will assist you in gaining an understanding of the services we offer to you and your family.

If you have any questions or concerns regarding the information within this packet, please do not hesitate to contact our staff at your convenience. We are committed to ensuring your absolute satisfaction.

*Nelson M. Handal, M.D.*

Nelson M. Handal, M.D.  
Medical Director

Board Certified Child, Adolescent,  
& Adult Psychiatrist

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## **I. INTRODUCTION**

### **MISSION STATEMENT:**

To serve our patients by meeting their total mental health care needs. We facilitate access to quality services in a pleasant, convenient, and caring environment with the highest standard of ethics and confidentiality. We are committed to the education of our patients and staff through research and continuing education.

## **II. PATIENT RIGHTS**

1. The right to notification of his or her rights.
2. The right to exercise individual rights regarding care.
3. The right to be informed of the policies and procedures governing patient conduct and duties of staff within the mental health clinic.
4. The right to be informed of services available, the charges of these services, and charges not covered by payer and charges
5. The right to be informed by a physician of his/her medical / mental health condition unless the physician orders otherwise. The patient can expect to be advised if the clinic proposes to engage in, or perform, research studies to examine the efficacy of treatment. (The patient is given the opportunity to take part in planning his/her care or treatment and given the choice of participating in experimental research to include refusal to participate in research projects.)
6. The right to receive from his/her physician information necessary to give informed consents prior to the start of any treatment.
7. The right to refuse treatment and to be informed of the medical consequences of his/her action.
8. The right to expect that every consideration of his/her privacy regarding medical / mental health care, case discussion, consultation, examination and treatment are confidential, and should be treated discreetly. Those not directly involved in his/her care should have permission from the patient to be present.
9. The right to expect that, within its capacity, a clinic must make a reasonable response to the request of a patient for service.
10. The right to care and treatment in a safe environment.
11. The right to expect reasonable continuity of care.
12. The right to know at all times the identity, professional status and professional credentials of healthcare personnel, as well as the name of the healthcare provider primarily responsible for his/her care.
13. The right to be informed of the facility's rules and regulations pertinent to patient and visitor conduct.
14. The right to examine and receive an explanation of his/her bill regardless of source of payment.

15. The right to be treated with consideration, respect and full recognition of dignity and individuality, including treatment and caring, or personal needs.
16. The right to designate a legal representative to act in his/her behalf.
17. The right to freedom from restraints used for the management of behavior unless clinically required.

### **III. PRIVACY NOTICE**

#### **CIVIL RIGHTS**

1. Be treated with dignity and respect
2. Retain all rights, benefits, and privileges guaranteed by law.
3. Consult with legal counsel at any time without hindrance.
4. To be protected from harm, including any form of abuse, neglect, or mistreatment.
5. To receive treatment and care in a safe and humane environment.

#### **DISCRIMINATION**

Be provided with impartial access to treatment, regardless of race, religion, sex, ethnicity, age, handicap, or source of financial support.

#### **CONFIDENTIALITY**

1. Protection of all confidential communications in accordance with applicable State and Federal laws and regulations.
2. Be informed of, and consent to, any information disclosed to any source and, if known, the benefits and disadvantages of releasing the information.
3. Be informed that provision of services shall not be contingent upon consent or refusal to consent to the release of information.
4. Be informed of, consent to, the purpose, present, and future use, and disposition of all products of special observation and audio-visual techniques, such as one-way mirrors, audio and visual recorders, movies or photographs.
5. To withdraw consent in writing for any release, at any time, without penalty.

#### **GRIEVANCES**

Grievances Process:

Dothan Behavioral Medicine Clinic patients shall be encouraged to discuss and remove complaint or grievance with the individual directly involved. If sufficient satisfaction is obtained, a grievance form shall be completed and submitted to the appropriate authority in ascending order of staff hierarchy: Assessment Specialist,

Office Administrator, Medical / Clinical Director. If necessary, the aggrieved patient shall be provided with an advocate to assist him/her in the preparation and processing of the formal grievance report.

All grievances shall be reviewed in a grievance hearing in accordance with established the Dothan Behavioral Medicine Clinic' policies within five (5) working days after submission of the formal grievances. A written report of the findings and recommendations of the hearing shall be provided to the patient, appropriate, his/her family, Assessment Specialist, Office Administrator, Executive Director, and Medical / Clinical Director and Governing Board within three (3) working days of the grievance hearing. The decision shall be final; however, the grievant shall retain the right to legal recourse.

### **PATIENT ADVOCATE**

Patients who believe their rights have been violated may contact the Regional Patient Advocate at: 1 – 800 – 367 – 0955

## **I V. OFFICE POLICIES**

### **MEDICATION POLICY**

Prescriptions are written at the time of your scheduled appointment.

Patients must follow up with routine office visits in order for prescriptions to be written/provided.

A follow up appointment must be scheduled before a prescription is written.

If 2 or more office visits have been missed, the physician must see you before any prescriptions will be written. (No Exceptions)

If a prescription is written for medication to be taken during school, **PLEASE** make sure a Release of Information Form and a Medication Form is completed before leaving the clinic.

Please remember to ask for a list of potential side effects of the medication prescribed.

### **SCHEDULING APPOINTMENTS**

#### **A. Appointments: How to Make and Reschedule an Appointment**

Patient Services is open for scheduling appointments from 8:00 am until 5:00 pm

Monday through Friday. Please state your problem, symptoms, and needs to the Patient Coordinator so he/she can schedule the proper amount of time for your appointment. Call toll free 866.224.2822

We know your time is valuable and we make every effort to keep to the appointment schedule. However, we are a mental health office and complicated or urgent cases are frequently referred to us. Some patients occasionally put us behind schedule. We appreciate your patience and understanding in these uncontrollable situations. **As a courtesy to our other patients, we would appreciate 24-hours notice of your cancellation. Failure to do so may result in you losing your appointment without a prescription. We generally can reschedule your appointment within a few days.**

## B. New Patient Appointments: What you might expect

Introducing CliniCom:

Dothan Behavioral Medicine Clinic has adopted a new technology as part of our new patient intake and assessment process. This program called CliniCom, is an interactive software program that is used by the adult patient or parent/guardian. The program includes a series of questions designed for a child/adolescent patient, and a series of questions designed for adult patients. This easy-to-use software program allows the patient or parent/guardian to include as much information as needed about symptoms, severity of symptoms, family history, and any additional information they wish to include. This is a benefit to the patient because CliniCom not only allows the user to include all information in a more private manner, but also allows the Doctor to see their patient's report before even meeting them. CliniCom can also be completed days before the patient's appointment, to have the patient report ready by check-in the day of their appointment.

New patient appointments are scheduled for one hour, depending on each case, times may vary. New appointments are handled by a Patient Coordinator. This skilled clinician is a Masters Level Psychologist. The initial evaluation may begin with an Intake Specialist who is responsible for gathering all the information needed to gain an understanding of how we may help you or your loved one. Several key elements will be helpful during this initial evaluation. Providing a complete family, medical, psychological, and educational history will assist with properly diagnosing and treating each individual case. Through our state of the art technology we are able to allow our patients to fill out intake information, progress, and assessment information online or in our lobby kiosks. You should call the patient coordinator if you need assistance with CliniCom.

### C. Follow – Up Appointments: What you might expect

Offices are open for appointments from 8:00 am until 5:00 pm Monday through Friday. Once you arrive to the office, we ask that you sign in; this way our Patient Services staff can update any changes in your information. You may be seen by an Assessment Specialist or nurse for the first part of the follow-up. Once the Assessment Specialist/nurse gathers the necessary information, the psychiatrist will then review the information with the patient and discuss recommendations.

Our office will attempt to contact you and confirm your appointment within 1–2 days prior to the scheduled appointment. It is your responsibility to confirm the appointment for which you are scheduled.

If your appointment is not confirmed, we will have to reschedule you for the next available appointment in accordance with our corporate office policies.

### D. Waiting List / Call In List

Occasionally, unexpected situations occur which prevents us from accomplishing all that is planned in a day and therefore appointment times are missed. We understand appointments are missed from time to time. In an effort to assist everyone who requires a follow up appointment, we work diligently to meet the needs of everyone. Therefore, as a helpful alternative we have developed a Call In List. The Call In List consists of names of those who are able to come in for an appointment time the day of a cancellation. If you miss your appointment and would like to be placed on our Call In List, we will call you if there is a cancellation so that you will be seen promptly. If you are unable to keep your appointment or if you miss a scheduled appointment, please contact our staff as soon as possible and request your name be placed on our Call In List.

### E. Telephone Calls

As previously indicated, office hours are from 8:00 a.m. until 5:00 p.m., Monday through Friday. As a courtesy to patients who are scheduled during these times, the receptionist will take telephone messages and calls will be returned between 4:30 p.m. and 6:30 p.m. by either the medical or clinical staff the same day the messages are left. *If you are experiencing an emergency (i.e. medication reaction, crisis situation) you must go to the nearest Emergency Room or Dial 911. For medication refills please contact the clinic before you or your child runs out of medication.*

## DOTHAN BEHAVIORAL MEDICINE CLINIC

### PATIENT INFORMATION

**IF PATIENT IS A MINOR PLEASE CHECK HERE**

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIPCODE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

TELEPHONE \_\_\_\_\_ CELLPHONE \_\_\_\_\_

PATIENT'S EMPLOYER \_\_\_\_\_

BUSINESS PHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_

### FILL OUT THE FOLLOWING IF PATIENT IS A MINOR

**(LEGAL GUARDIAN)**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SSN \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP CODE

PLACE OF EMPLOYMENT \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SSN \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP CODE

PLACE OF EMPLOYMENT \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

WHOM SHOULD WE CONTACT IN CASE OF  
EMERGENCY? \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_ PHONE \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE COMPANY \_\_\_\_\_

PHONE \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

CONTRACT/POLICY \_\_\_\_\_ GROUP \_\_\_\_\_

SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

SECONDARY INSURANCE COMPANY \_\_\_\_\_

PHONE \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

CONTRACT/POLICY \_\_\_\_\_ GROUP \_\_\_\_\_

SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

I, \_\_\_\_\_ GIVE DOTHAN BEHAVIORAL MEDICINE CLINIC PERMISSION TO FILE MY INSURANCE AND REQUEST PAYMENT. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ALL CHARGES NOT PAID BY THE INSURANCE COMPANY.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**FINANCIAL AGREEMENT**

ALL OFFICE CHARGES ARE TO BE PAID AT THE TIME OF THE VISIT. YOU ARE RESPONSIBLE FOR ALL DEDUCTIBLES, CO-PAYS, AND NON-COVERED CHARGES.

### COLLECTION AGREEMENT

IF YOUR ACCOUNT SHOULD BECOME DELINQUENT MORE THAN 60 DAYS, IT WILL BE TURNED OVER TO A COLLECTION AGENCY.

### AGREEMENT TO PAY

THE UNDERSIGNED STATES THAT YOU AGREE AND ACCEPT THE FEE CHARGED AS A LAWFUL DEBT AND PROMISES TO PAY SAID FEE INCLUDING THE COLLECTION FEE UP TO 40% OF THE PRINCIPAL BALANCE, ATTORNEY

FEES, AND COURT COSTS IF SUCH IS NECESSARY WAIVING NOW AND FOREVER THE RIGHT TO DISPUTE ANY ADDITIONAL COSTS DUE TO NON-PAYMENT.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

WITNESS \_\_\_\_\_ DATE \_\_\_\_\_

### CONSENT FOR INTERVENTIONS AND TREATMENT FOR ALL PATIENTS AT A DOTHAN BEHAVIORAL MEDICINE CLINIC

1. **MEDICAL CONSENT:** You are hereby giving consent for medical treatment and procedures (except for complex procedures which require special consent), including therapy, psychological testing, prescription of medication, urine drug screening, drawing blood for tests, injections, taking photographs, videotaping, laboratory procedures, and other services rendered under the general and special instructions of the attending physicians or other clinicians of Dothan Behavioral Medicine Clinic assisting in your care.
2. **REQUIREMENTS:** You must tell the doctor and the assessment specialist about your illnesses and medicines and be willing to fill out questionnaires.
3. **MEDICATION:** Medication treatment, drug selection, and treatment options will be discussed with you if medications will be considered for your treatment. In certain circumstances the attending physician may choose to offer treatment with medications prescribed "off label" meaning that they are not FDA approved for a specific age or condition.
4. **RISKS:** The medication(s) you and the attending physician choose may cause adverse drug reactions such as: headaches, palpitations, vomiting, tics, severe

rash, hallucinations, constipation, dry mouth, cramps, seizures, dizziness, agitation, muscle rigidity, sedation, diarrhea, blurred vision, seizures, trouble sleeping, sinus problems, sweating, feeling hot, muscle pain, numbness of hands and feet, lack of appetite, abnormal movements, mood instability, irritability, or anger.

5. ALLERGIC REACTION: You may experience symptoms of sensitivity or an allergic reaction from medication(s) prescribed. These include rash, hives, and difficulty breathing and swelling of the face. Any of these symptoms may be severe. If you have any of the above symptoms or any other problems, or become pregnant, you must stop the medication immediately, tell the doctor or nurse right away and/or go to an emergency room.

6. WHO TO CALL: If you experience any adverse drug reactions, allergies, sensitivities to medications prescribed at the Dothan Behavioral Medicine Clinic or if you have any questions related to diagnosis or treatment, or if you become a danger to self or others you should contact us at 866-224-2822 (line available day or night, 365 days a year) and/or go to the closest emergency room.

7. THERAPY: You may be offered therapy at DBMC as a treatment option combined or not with medications. You consent with this treatment option if recommended by the attending physician, psychologist or counselor.

8. TESTING: You may be offered psychological testing at DBMC as a procedural option. You consent with this option if recommended by the attending physician, psychologist or counselor.

9. CONSENT: My signature below indicates that I have read the above and had a chance to ask questions to help me understand what my participation as a patient of DBMC will involve and give consent for interventions and treatment.

**IF PATIENT IS A MINOR FILL OUT ONLY SECTION B \***

*\* Under current law, this means a single individual under 19 years of age and a married individual less than 18 years of age*

**SECTION A**

I have read, agreed to and received a copy of this Consent.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name Printed

\_\_\_\_\_  
Signature of Person Obtaining Consent

Dothan Behavioral Medicine Clinic

Patient Name \_\_\_\_\_

**SECTION B** *THE FOLLOWING IS TO BE SIGNED BY LEGAL GUARDIAN ONLY!*

I have read, agreed to and received a copy of this Consent.

\_\_\_\_\_  
Parent or Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian's Name Printed

\_\_\_\_\_  
Patients Name Printed

Signature of Person Obtaining

Consent \_\_\_\_\_

## DOTHAN BEHAVIORAL MEDICINE CLINIC

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### STATEMENT OF UNDERSTANDING REGARDING CONFIDENTIALITY

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We are proud that you have decided to choose Dothan Behavioral Medicine Clinic. There are several things we want you to know before we begin providing quality services to you.

Personal problems are sometimes difficult to talk about. For this reason, assurance of confidentiality is extremely important. We take every precaution in protecting the confidentiality of your visit with us and we hope that you will do the same.

WE DO NOT DISCUSS YOUR SITUATION WITH ANYONE EXCEPT FOR REASONS CITED BELOW, UNLESS YOU GIVE US WRITTEN PERMISSION TO DO SO. THERE ARE SEVERAL LIMITATIONS TO CONFIDENTIALITY THAT ARE BEYOND YOUR CONTROL:

1. If we learn about child abuse or abuse of disabled adults, we are required by law to report it to the proper authorities.
2. If, in our judgment, a client is dangerous to himself or others (suicidal or homicidal), we will disclose information in order to help protect the person from harm.
3. If we are required to present records to comply with a court order, it is our legal responsibility to comply.
4. In providing services to adolescents, there may be limits in the confidentiality of information between parent and adolescent.

THIS PROVIDES A SAFE AND SECURE OPPORTUNITY FOR YOU TO DISCUSS PERSONAL PROBLEMS WITH US. WE WILL HELP YOU WITH AN ASSESSMENT OF YOUR PERSONAL PROBLEMS AND THEN WILL HELP YOU DEVELOP A PLAN OF ACTION, WHICH WILL INCLUDE OUR TREATMENT RECOMMENDATIONS.

**DOTHAN BEHAVIORAL MEDICINE CLINIC****PRIVACY NOTICE**

This notice describes the type of information we gather about you, with whom that information may be shared and the safeguards we have in place to protect it. You have the right to the confidentiality of your health information and the right to approve or refuse the release of specific information except when the release is required by law.

**OUR PLEDGE REGARDING YOUR HEALTH INFORMATION:** We understand that information about you and your health is personal. Protecting health information about you is important. We create a record of care and services you receive. We need this record to provide you with consistent quality care and to comply with regulatory agencies. This notice applies to all of the records of your care generated by the Dothan Behavioral Medicine Clinic. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

**USES AND DISCLOSURES OF YOUR HEALTH INFORMATION:**

We will use and disclose elements of your protected health information (PHI) in the following ways:

**With Your Signed Consent:**

*Treatment:* Means the provision, coordination, or management of your medical and clinical health care, including consultations between your Dothan Behavioral Medicine Clinic staff providers.

*Follow-up:* Means contact made after the Initial Evaluation for follow-up studies and Progress updates.

**With Your Signed Authorization:**

Means activities we undertake to obtain reimbursement for health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

**Progress Reporting:**

Means activities we undertake to keep school officials (or any other persons directly related to the care of your child/family member) informed of his/her progress in regards to treatment. Authorization is also required for any disclosure of your protected health care information to any person(s) or agencies.

Except for the special situations set forth below, we will not use or disclose your protected health information for any other purposes unless you provide written authorization. You have the right to revoke that authorization at any time, provided the revocation is in writing, except to the extent that we have taken action in reliance on your authorization.

**Special Situations:**

**Public Health Risks:** We may disclose protected health information for public health activities such as: (1) Prevention and control of disease; and/or (2) To report child abuse or neglect.

**Law Enforcement:** We may release privileged health information if asked to do so by a law enforcement individual: (1) In response to a court order; and/or (2) About criminal conduct on our premises.

**Serious Threats:** As permitted by applicable law and standards of ethical conduct, we may disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public.

**Emergency:** We may disclose protected health information in a care situation where you are incapable of giving consent.

**Military:** If you are a member of the armed forces, we may release information about you as required by military authorities.

**Coroners:** We may release information to a coroner or medical examiner for identification or to determine the cause of death.

**National Security:** We may release information about you to authorized officers so they may provide protection to the president, as well as other national security activities authorized by law

**YOUR RIGHTS:**

1. You have the right to inspect and request a copy of the health care information that may be used to make decisions about your care. Usually this includes medical and billing records, but may not include psychotherapy notes.

• To inspect and request a copy of your health care information, you must submit your request in writing to: *Dothan Behavioral Medicine Clinic, Attn: Medical Records Department, 101 Medical Drive, Dothan, AL 36303.*

• If you request a copy of the information, we will charge a fee for the cost of copying, mailing, or other supplies associated with your request.

2. If you feel that health care information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Clinical/Medical Director. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (1) Was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (2) Is not part of the health information kept by Dothan Behavioral Medicine Clinic; or (3) Is accurate or complete.

3. You have the right to request an "account disclosure." This is a list of the disclosures we made of health information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Clinical/Medical Director. Your dates may not include dates before April 14, 2003.

4. You have a right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. To request restrictions, you must make your request in writing to the Clinical/Medical Director. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

5. You have the right to request that we communicate with you about health care matters in a certain way or at a certain location. For example, you can ask that we only contact you at home or by mail.

**CHANGES TO THIS NOTICE:** We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice. This notice will contain on every page, in the bottom left hand corner, the effective date.

**COMPLAINTS:** If you believe your privacy rights have been violated, you may file a complaint with Dothan Behavioral Medicine Clinic. To file a complaint with DBMC, contact our Privacy Officer at the address and phone number below. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

**PRIVACY OFFICER:**

Tami Johnson

*Chief Privacy Officer*

101 Medical Drive Dothan, Alabama 36303 866-224-2822

**OTHER USES OF HEALTH INFORMATION:** Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, thereafter we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your

permission, and that we are required to retain our records of the care that we have provided to you. Dothan Behavioral Medicine Clinic / HIPPA PRIVACY NOTICE: 04142004  
FORM 1002-A

## DOTHAN BEHAVIORAL MEDICINE CLINIC

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### ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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The Health Insurance Portability and Accountability Act of 1996 requires that health care providers give patients a copy of the office Notice of Privacy Practices and make a good faith effort to obtain an acknowledgement of receipt of same. You may refuse to sign this acknowledgement form.

By signing this form I confirm that I have received a copy of the Notice of Privacy Practices.

**(Office use only) Case Number:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Sign Name:** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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**Written acknowledgement was not obtained**

- a. Patient refused to sign
- b. Emergency situation
- c. Unable to communicate with patient
- d. Other \_\_\_\_\_

\_\_\_\_\_  
(Witness Signature)

\_\_\_\_\_  
(Date)

*Note: Future changes in federal and state law may mandate revisions.*