Edmond Family Counseling, Inc.
1251 N. Broadway, Suite C
Edmond, Oklahoma 73034
Phone: 341-3554 Fax: 341-3511
www.edmondfamilycounseling.org

Edmond Family Counseling, Inc. is a community counseling agency committed to improving lives by providing counseling and educational programs to individuals, families, and groups. A sliding scale is available to youth and adults with substance abuse issues. Services to children, ages 7 to 18, are also provided on a sliding scale. Other adult counseling services are provided on a sliding fee scale which is determined at intake.

To access services, please drop by our agency, located at 1251 N. Broadway, Suite C, Edmond, Oklahoma, and pick up an intake packet, **pay the $25 NONREFUNDABLE intake fee**, and make your intake session appointment. **Proof of income, in the form of the past year's federal tax return, an IEP Transmittal letter** (if applicable), or proof of state custody is required by EFC. (We'll be happy to make copies and return your originals.)

If you are unable to attend your intake appointment as scheduled, **please** call our office (341-3554) to cancel your appointment. This will allow another individual or family to access services. Thank you for your consideration.

All individuals who are to be involved in the counseling process must be present at the intake appointment. This helps in determining the best staff counselor for the client. In the case of a minor child (individual under the age of 18 in the state of Oklahoma), a custodial parent (parent who has majority custody) or legal guardian must be present at the intake appointment.

Failure to fully complete the attached information and provide proof of income will result in your intake being placed on hold until the information is provided to Edmond Family Counseling.

Thank you for your time and attention to these details.

Sheila Stinnett, M.A., LPC
Executive Director
Edmond Family Counseling, Inc.

NOTE: Upon completion of the initial intake session, an individual, couple or family becomes a client of Edmond Family Counseling. If for any reason the intake session is not completed, the person or persons are NOT clients of EFC until that process is finalized.

Is This Alcohol and/or other Drug Related? ☐ **Yes** ☐ **No** _____initials

Office use only	
Therapist 1st contact Date: _____	Receipt of Intake Date: _____
Left Voicemail: Y N	Initials: _____

NO INTAKE CAN BE CONDUCTED WITHOUT COMPLETED INTAKE PAPERWORK, PROOF OF INCOME IN THE FORM OF LAST YEAR'S TAX RETURN, PROOF OF STATE CUSTODY, OR AN IEP TRANSMITTAL LETTER. FAILURE TO BRING PROOF OF INCOME OR INCOMPLETE PAPERWORK WILL RESULT IN SCHEDULING OF A NEW INTAKE SESSION AND PAYMENT OF $25 FOR THAT SESSION.

Please Initial Here _____

CLIENT INFORMATION ***(Person for whom services are being sought)***

_____ _____ _____
Client First Name M.I. Last Name

_____ _____ ____/____/_____
Maiden Name (if applicable) Social Security Number Date of Birth

☐ Male ☐ Female Age:_____ Race:_____ Preferred Pronouns:_____

_____
Address City Zip Code

Home Phone #:_____ Other Phone #:_____ Household Income (Gross):_____

Place of Employment (if applicable):_____ Phone Number:_____

School Attending (if applicable):_____ Grade:_____

EMERGENCY CONTACT ***(If client is under 18, please list legal guardian)***

_____ _____
First Name Last Name

_____
Address City Zip Code

Emergency contact number_____Relationship:_____

If client is under 18, please complete

Mothers Name:_____ Where Employed: _____
Address: _____City:_____ Zip:_____

Fathers Name:_____ Where Employed: _____
Address: _____ City:_____ Zip: _____

Stepmother's Name:_____ Resides with Client? Yes☐ No☐
Where employed:_____

Stepfather's Name: _____ Resides with Client? Yes☐ No☐
Where employed:_____

Who is/are the legal guardian(s)? _____

Client ID#_____ **CONFIDENTIAL**

HEALTH HISTORY

Primary Care Physician _____ Phone Number _____

Address _____ City _____ Zip Code _____

Does Client have any past or significant Medical Problems and/or Diagnosis? ☐Yes ☐No
If yes, please describe: _____

Is client currently taking any medications? ☐Yes ☐No If yes, list medicine and dosage.

Does client have any allergies or adverse reactions? _____

BEHAVIORAL HEALTH

Has client been seen by a therapist/counselor or psychiatrist before? ☐Yes ☐No

If so, please list clinician name, address and dates seen: _____

For what reason(s): _____

WHO REFERRED YOU? *(Please check all that apply)* ☐Self ☐Parent ☐Family
☐Friend ☐School ☐Juvenile Court ☐Other Court ☐Probation Officer
☐Law Enforcement ☐Fire Department ☐Physician ☐Private Therapist ☐Lawyer
☐Church ☐Telephone Book

REFERRAL REASON *(Please check all that apply):* ☐Suicide Issues ☐Sexual Abuse
☐Physical Abuse ☐Domestic Violence ☐Home/Family problems ☐Marital ☐Divorce
☐Death of a family member ☐Death of a friend ☐Law Violation ☐Depression
☐Employment Problems ☐Anger Management ☐Severe Injury/Accident ☐Anxiety
☐Drug/Alcohol Problems by Client ☐Drug/Alcohol Problems by Significant Other
☐Other Reason *(describe)* _____

I WOULD LIKE TO WORK ON: _____

ACKNOWLEDGMENTS AND CONSENT FOR TREATMENT

I. CLIENT RIGHTS (Copies attached to intake packet for your removal)

II. CONFIDENTIALITY (Copies attached to intake packet for your removal)

III. EXCEPTIONS TO CONFIDENTIALITY

Our Agency shall meet the requirements of all applicable state and federal laws, rules, and regulations. Public Law 99-401, amends the federal confidentiality laws to require that cases involving suspected, actual, or imminent harm to children must be reported to child protection agencies and therefore are not covered by confidentiality requirements. This applies only to initial reports of child abuse or neglect and not to requests for additional information or records. Court orders are still required before records may be used to initiate or substantiate any criminal charge or to conduct any investigation of a patient.

Client records will not be released to other individuals or agencies without your expressed written consent, except upon receipt of a legitimate subpoena, in the event of a valid medical emergency, to meet the requirements of state law that child/elderly abuse is reported or in the event you present a danger to yourself or to others.

Since part of the cost of your treatment may be paid by federal, state, or local sources, these sources have the right to review client files to verify that these services have been delivered appropriately. This review is done for accounting or evaluative purposes only, with no files or clinical information removed from this agency. Others having review access to your file are agency staff, consultants, and accountants.

Edmond Family Counseling is a training site for several universities' counseling programs. A part of this training requires practicum interns to record some sessions for supervisory purposes. These recordings are protected by the same rights and responsibilities as all clinical records.

IV. CONSENT FOR TREATMENT

1. I, We authorize Edmond Family Counseling, Inc. to provide services to me/us and to continue such services as deemed necessary.

2. I/We hereby authorize counseling services by the therapist authorized by Edmond Family Counseling, Inc. I/We understand that this consent is given before any service is provided, but is given to authorize Edmond Family Counseling, Inc. to exercise their judgment in providing services.

3. I/We agree to be actively involved in the treatment plan as prescribed by my/our therapist. I/We understand that included in this treatment plan would be my/our involvement in regular family, individual, or group therapy sessions.

4. I/We understand that no guarantees are given by anyone as to the results that may be obtained from counseling.

5. I/We consent to being contacted after discharge for the purpose of obtaining information in efforts to improve the quality of care (e.g., client satisfaction surveys, etc.).

Client Name: _____ **Client ID#** _____ **Confidential**

THIS CONSENT SHALL REMAIN IN EFFECT COMMENCING ON THE DATE OF ADMISSION UNTIL THE CLIENT HAS BEEN DISCHARGED; AND FOR THE PURPOSES OF FOLLOW UP, UNLESS REVOKED IN WRITING AND DELIVERED TO EDMOND FAMILY COUNSELING, INC.

ACKNOWLEDGMENTS AND SIGNATURES

1. I/We have provided the information in the "Intake Forms" and, upon review, find it to be accurate to the best of my/our knowledge.

2. I/We have received a copy of the Client Bill of Rights and Confidentiality Rules.
   _____I requested and received a **complete copy** of the Client Bill of Rights.

3. I/We have received, read, and understand the statement in Section III. (Exceptions to Confidentiality).

4. I/We have read Section IV (Consent for Treatment), understand all of its contents and sign my/our name(s) freely, voluntarily and without coercion.

5. I/We agree to give 24 hours notice of cancellation if not participating in planned services and understand that if I/we do not show up for planned services, the treatment plan may be reviewed to determine the appropriateness of continued treatment or, possibly, discharge.

6. I/We consent to being contacted by email or phone after discharge for the purpose of obtaining information in efforts to improve the quality of care (e.g. client satisfaction surveys).
   I agree to be contacted: Yes____ No___

   If consent is given, please provide preferred email to use for survey _____

7. **If client is under the age of 18, please indicate one of the following by providing your initials:**

   _____ My child is currently enrolled in an Oklahoma Public School and is compliant with all State of Oklahoma regulations regarding immunizations for public school attendance.

   _____ As a parent, I choose to exercise my right by law to excuse my child from receiving scheduled immunizations as recommended by the State of Oklahoma

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian (if applicable) Date

_____ _____
Signature of Staff/Witness Date

Client Name: _____ **Client ID#** _____ **Confidential**

EDMOND FAMILY COUNSELING, INC.
CLIENT AND AGENCY RIGHTS AND RESPONSIBILITIES

1. **Negotiation:** The frequency, number, and goals of your counseling sessions will be negotiated between you and your counselor(s) during the first or second sessions. You are encouraged to discuss your progress and goals at any time during the counseling process.

2. **Questions:** If you have any questions about methods used by your counselor you should discuss them with your counselor. If you should still have questions after the discussion you may request to see the Case Manager or Executive Director to discuss your concerns.

3. **Termination:** Termination is usually a mutual agreement between you and your counselor. If you feel that you are not making progress towards the goals you have set and wish to terminate, you may ask your counselor to refer you to another counselor or agency. We would like to talk with you about your concerns so we may continue to improve our services.

4. **Participation:** In order for your counseling to be effective, it is necessary for you to take an active role in the process. Active participation usually consists of listening, being honest, discussing concerns with the counselor, completing outside assignments, and providing feedback to the counselor about the process.

EDMOND FAMILY COUNSELING RESPONSIBLITIES

1. In the event that the agency or counselor must cancel an appointment, Edmond Family Counseling will attempt to contact the client 24 hours in advance or as soon as it is apparent that the cancellation must occur.

2. Termination and Referral: Edmond Family Counseling counselors make every effort to provide you with the best counseling available. When we feel that our services are not or will not be appropriate we may, after discussing our concerns with you, decide to terminate counseling with you as our client and refer you to a more appropriate service.

We look forward to providing our services to you.

Edmond Family Counseling Administration and Staff

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

Client Name: _____ **Client ID#** _____ **Confidential**

Edmond Family Counseling, Inc.

Consent for Use and Disclosure of Health Information

I _____, understand that as part of my/ or my child's health care, Edmond Family Counseling, Inc. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

> A basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals, a means by which a third-party payer can verify that services billed were actually provided, and a source of information for applying my diagnosis and treatment to my bill.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges.

> The right to review the notice prior to signing this consent, the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Edmond Family Counseling, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization my refuse to treat me as permitted by Section 164.596 of the Code of Federal Regulations.

I further understand that Edmond Family Counseling, Inc. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.529 of the Code of Federal Regulations. Should Edmond Family Counseling, Inc. change their notice, they will provide me with a revised notice.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept

I give Edmond Family Counseling staff permission to leave a message at this number/s:

_____ Home ☐ Work ☐ Cell ☐

_____ Home ☐ Work ☐ Cell ☐

Client Signature:_____

Signature of Parent/Guardian (if applicable):_____ Date:_____

FOR INTERNAL OFFICE USE ONLY
[ ] Consent received by _____ on _____.
[ ] Consent refused by client, and treatment refused as permitted.
[ ] Consent added to the client's record on _____

Client Name: _____ **Client ID#** _____ **Confidential**

CLIENT INFORMATION

HIV/AIDS/STD/TB TESTING

____ I accept for myself, information including referral, education, testing, and counseling regarding HIV/AIDS, STD's, TB and/or other communicable diseases.

____ I decline for myself, information including referral, education, testing, and counseling regarding HIV/AIDS, STD's, TB and/or other communicable diseases.

____ I accept for spouse or significant other, information including referral, education, testing, and counseling regarding HIV/AIDS, STD's, TB and/or other communicable diseases.

____ I decline for spouse or significant other, information including referral, education, testing, and counseling regarding HIV/AIDS, STD's, TB and/or other communicable diseases.

I have read (or have had read to me) the above information.

_____ _____

Client's Signature Date

HIV/AIDS/STD/TB Testing Sites

Oklahoma City-County Health Department
921 N.E. 23rd Street
Oklahoma City, OK 73105
Phone: 425-4430
*HIV testing and pre-and post-counseling are available Monday thru Friday. Call for times.
**There is a $5 charge for this service, results are available after two weeks and must be obtained in person. This a confidential test site but no longer anonymous.

OU Health Sciences Center
900 NE 10th
OOKC, OK 73104
271-4311 clinic for STD testing
271-2577 clinic for TB testing $12.50

TB Testing Sites

Concentra Medical Center
6101 W. Reno, Suite 800
Oklahoma City, OK 73127
Phone: 495-3085
*$32.50 fee

CCHDOC TB Control Center
400 N.E. 50th
OKC, OK 73105
Phone: 419-4000

Edmond Family Counseling staff counselors are also available to provide information and counseling regarding HIV/AIDS/STD and TB.

Client Name: _____ **Client ID#** _____ Confidential EFC 2/11

EDMOND FAMILY COUNSELING, INC.
1251 N. BROADWAY, SUITE C
EDMOND, OKLAHOMA
(405) 341-3554 fax: (405) 341-3511
www.edmondfamilycounseling.org

SERVICES

Individual, couples, family, group and crisis counseling covering a variety of presenting issues including: Parenting, Anger Management, Communication Skills, Body Image, Anxiety-Depression, Children's Behaviors, Teen Behaviors, Low Self-Esteem, Premarital & Marital, Divorce/Divorce Recovery, Emotional Abuse, Sexual Abuse, Physical Abuse, Co-Dependency, Difficulties, Developmental Disorders, Chronic Illness, Empty Nest Syndrome and Life Transitions. Edmond Family Counseling also offers the First Time Offender Program (SKILLS). A Speaker's Bureau provides presentations on current relevant mental health topics.

HOURS OF OPERATION

9am to 8pm, Monday thru Thursday
Friday by Appointment only

CRISIS PROGRAM

Edmond Family Counseling provides crisis services during regular business hours (Monday-Thursday 9am-8pm). Edmond Family Counseling can provide up to three sessions of crisis management and linkage services free of charge to individuals not currently accessing services at the agency as well as crisis management to current clients and their families. To speak with a counselor about crisis services, please call the office (405-341-3554) and you will be connected to the current on-call counselor. If **immediate** crisis services are needed, please **dial 988, 911 or go to the nearest emergency room**.

GRIEVANCE POLICY

Edmond Family Counseling, Inc. has adopted a complaint resolution system designed to ensure fair consideration of complaints made by or on behalf of clients in the care of Edmond Family Counseling, Inc. The filing of a complaint or grievance will not result in any retaliation or barrier to continued care or future services. EFC's clinical director, John Goetz, will serve as local advocate for the client, he will work with agency staff and contractors to ensure the needs of clients are meet at the lowest level possible and that client rights are not violated. EFC's Administrative Manager, Justice Hernandez, will serve as the coordinator of the program. EFC's Executive Director, Sheila Stinnett, serves as the person responsible/authorized to make decisions for the resolution of the grievance. For those wishing to initiate a grievance, a white notebook containing the agency's policy, instructions and grievance forms is located in the lobby.

OTHER INFORMATION

Edmond Family Counseling is a **smoke and tobacco free campus**.

Edmond Family Counseling provides a drug-free environment. It the policy of this agency to prohibit the use of illegal drugs and alcohol and the misuse or abuse of legal & prescription medications.

Edmond Family Counseling's policy does not allow for transportation of its clients.

NO weapons are allowed in the building or on the premises.

Revised 10/2019

EDMOND FAMILY COUNSELING, INC.
BILL OF RIGHTS

Each consumer has the right to be treated with respect and dignity.

1. Each consumer shall retain all rights, benefits, and privileges guaranteed by law except those lost through due process of law.

2. Each consumer has the right to receive services suited to his or her condition in a safe, sanitary and humane treatment environment regardless of race religion, gender, ethnicity, age, degree of disability, handicapping condition or sexual orientation.

3. No consumer shall be neglected or sexually, physically verbally, or otherwise abused. It is against Edmond Family Counseling to seclude or restrain clients at any time.

4. Each consumer shall be provided with prompt, competent, and appropriate treatment; and an individualized treatment plan. A consumer shall participate in his or her treatment programs and may consent or refuse to consent to the proposed treatment. The right to consent or refuse to consent may be abridged for those consumers adjudged incompetent by a court of competent jurisdiction and in emergency situations defined by law. Additionally, each consumer shall have the right to the following:
   A. Allow other individuals of the consumer's choice participate in the consumer's treatment and with the consumer's consent;
   B. To be free from unnecessary, inappropriate, or excessive treatment;
   C. To participate in consumer's own treatment planning;
   D. To receive treatment for co-occurring disorders if present;
   E. To not be subject to unnecessary, inappropriate, or unsafe termination from treatment; and
   F. To not be discharged for displaying symptoms of the consumer's disorder.

5. Every consumer's records shall be treated in a confidential manner.

6. No consumer shall be required to participate in any research project or medical experiment without his or her informed consent as defined by law. Refusal to participate shall not affect the services available to the consumer.

7. Each consumer shall have the right to assert grievances with respect to an alleged infringement on his or her rights.

8. Each consumer has the right to request the opinion of an outside medical or psychiatric consultant, access or referral to legal entities for appropriate representation at his or her own expense or the right to an internal consultation upon request at no expense to the consumer.

9. No consumer shall ever be retaliated against or subjected to any adverse change of conditions or treatment because the client/consumer asserted his or her rights.

At any time you may call:
Office of Juvenile Affairs General Advocate: P.O. Box 268812 OKC, OK 73126-8812 Phone #: 405-530-2939

CLIENT COPY

SUMMARY OF STATE (43A O.S. 3-422 & 3-423) CONFIDENTIALITY RULES

Client records and clinical information are confidential and are protected under the provisions of 43A O.S. paragraphs 3-422 & 3-423; and of (U.S.) 42CFR Part 2. For clients who have not been referred from the criminal justice system the policies and procedures of Edmond Family Counseling, Inc. shall include, but not be limited to:

1. Medical records and all communications between client and doctor or psychotherapist are privileged and confidential; with such information limited to persons/agencies actively engaged in treatment of the client or related administrative tasks.
2. Privileged/confidential information shall not be released to any person or entity not involved in the client=s treatment without the written, informed consent of the client, or his/her guardian, or parent of a minor child, or a private or public child care agency having legal custody of the minor child.
3. Identifying information may be released without the consent required above when:
   - A. It is required to fulfill any statutorily required reporting of child abuse (10 O.S. par. 7005 (1.7) and abuse of elderly or incapacitated adults (43A O.S. par. 10-104); or
   - B. As provided by 10 O.S. par. 7005 (1.1) through 7005 (1.3); or
   - C. On the order of a court of competent jurisdiction; or
   - D. Holders of contracts with ODMHSAS having signed a qualified service agreement (43A O.S. par. 1-109 (A)(2), as provided by said contract. These facilities shall have policy and procedures to permit transmittal of records and information regarding the care and treatment of a specific client as necessary and appropriate between them and/or the ODMHSAS, and/or another contracted holder of a qualified service agreement.
4. Restricting personal access of present or former clients to their records in a manner conforming to 43A O.S. par. 1-109 (B)
5. With the consent of the client, providing information to responsible family members as provided and limited in 43A O.S. par. 1-109 (C)(1-5).
6. The reviews of records by state or federal accrediting, certifying, or funding agencies may occur to verify services and/or facility compliance with statutes and/or regulations.

SUMMARY OF FEDERAL CONFIDENTIALITY RULES (42 CFR Part 2)

The confidentiality of alcohol and drug abuse client records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser **Unless**:

1. The patient consents in writing
2. The disclosure is allowed by a court order, or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a client either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

CONFIDENTIAL

Edmond Family Counseling, Inc.

Notice of Privacy Practices

This notice talks about **privacy information**. This is nothing new. We've always taken great care to safeguard your privacy. What **is** new is a government regulation requiring us to explain your rights.

This notice describes how medical and mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. In the event that the notice is changed, a new notice will be sent to you by mail or at the time of your next appointment. You may request a copy of our Notice at any time.

This notice takes effect April 14, 2003, and will remain in effect until we replace it.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked to sign a consent form. Once you have consented to the use and disclosure of your protected health information for treatment by signing the consent form, this agency will use or disclose your protected health information as described below.

Treatment: We may use and disclose, as needed, your protected health information to provide, coordinate, or manage your health care and any related services.

Healthcare Operations: We may use and disclose, as needed, your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of mental healthcare professionals, evaluating practitioner and provider performance, employee review activities, conducting training programs, accreditation, certification, licensing or credentialing activities, and conducting or arranging for other business activities.

Uses and Disclosures of protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment, disclosing only health information that is directly relevant to the person□s involvement in your healthcare.

Other permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
Health Oversight: We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Abuse or Neglect: We may disclose your protected health information to the Department of Human Services which is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse or neglect to the Department of Human Services. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages or letters).

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et.seq.

Client Rights

Access: You have the right to inspect and copy your protected health information. We will use the format you request unless we cannot practicably do so. You must submit your request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If your request copies, we will charge you $1.00 for the first page, and $.25 each page thereafter to locate and copy your health information plus postage if you want the copies mailed to you. .

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Restriction: You have the right to request a restriction of your protected health information. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. If we agree to the additional restrictions we will abide by our agreement (except in an emergency).

We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected information will not be restricted.

Alternative Communication: You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You must make your request in writing.

Amendment Request: You have the right to request that we amend your protected health information. Your request must be in writing and explain why the information should be amended. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Disclosure Accounting: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment or healthcare operations as described in this Notice of Privacy Practices.

Notice: You have the right to obtain a paper copy of this notice from us upon request.

Questions and Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We support your right to the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

You may contact our Privacy Officer below for further information about the complaint process.

Attn: EFC Privacy Officer
1251 N. Broadway, Ste. C
Edmond, OK 73034
(405) 341-3554