The Oak Bower, LLC
Amber McEachern, PhD
www.theoakbower.com

Privacy Policy: Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get a paper copy of your medical record and other health information we have about you.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care, or if the request is required by law or by the current Ethical Principles of Psychologists and Code of Conduct published by the America Psychological Association.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/** .
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest.*
- *We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In the following cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways:

Treat you

- We can use your health information and share it with other professionals who are treating you.
- *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- *Example: We use health information about you to manage your treatment and services.*

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.
- *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html** .

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to one's health or safety, including yourself or others

Do research

We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to assess that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**
- **For more information see:** www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html **.**

Changes to the Terms of this Notice

- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Privacy Notices for The Oak Bower

The Oak Bower, LLC privacy official: Dr. Amber D. McEachern (505) 503-1959

Special notes that apply The Oak Bower's privacy practices

- We never market or sell personal information.

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Amber McEachern, PhD
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Summary of the Privacy Policy for The Oak Bower

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

By signing below, I affirm that I have read and understood The Oak Bower's Privacy Policy, as summarized above. Further, I affirm that I have been given an opportunity to ask questions and have been provided a copy of the Oak Bower's three-page detailed Privacy Policy.

Printed Name: _____ Date: _____

Signature: _____

Informed Consent

You can expect the attention, respect, and best professional efforts of your mental health provider. Your provider will treat you as a responsible individual and will expect you to take an active role in your treatment. You should understand the goals and direction therapy is taking, and if you do not understand, you should ask. To better equip you to start treatment and understand some ground rules, the information below is provided:

To schedule follow-ups or cancel appointments, you can reach The Oak Bower by calling 505-503-1959.

Limits to Services

The Oak Bower does **not** provide mental health (MH) emergency services, does **not** accept walk-in patients, and is **not** available for 24/7 consultation. If you have a MH emergency, you should immediately go to the nearest emergency room or call 911. Suicide hotline services are also available locally (505-277-3013) and nationally (1-800-273-8255)

Confidentiality/Disclosure Policy Exceptions

- Danger to Self or Others. Providers must take steps to protect individuals from harm when a patient presents a serious threat to the life or safety of self or others.
- Abuse to a Vulnerable Population. Providers must report suspected child abuse/neglect, suspected elder abuse/neglect, and/or suspected abuse or neglect to any other vulnerable population (e.g., disabled individuals) to relevant protective authorities and/or law enforcement.
- Court Order or Other Lawful Demand. Providers must obey court orders (e.g., subpoenas) and other lawful demands requiring release of records.

Records of Your Care

Each of your clinical visits to The Oak Bower are documented in your medical record. Generally, only your primary MH provider is allowed to view these sensitive records (see Confidentiality section, as well The Oak Bower's Privacy Policy for additional information). After you terminate care at The Oak Bower, your MH record will be maintained at The Oak Bower and will permanently be subject to the privacy practices outlined in The Oak Bower's Privacy Policy. The American Psychological Association (APA, 2008) requires that records are maintained in their entirety for 7 years after the last date of service or 3 years after a minor patient reaches majority age. Records will be disposed of confidentially, and in accordance with state and federal law.

Disclosure Policy for All Patients

The privacy of patients is protected by the Federal Privacy Act. Your health information may be used or disclosed for treatment, payment, and health care operations. Most other information related to the treatment of patients is not releasable without the written consent of the patient (see Confidentiality section, as well as The Oak Bower's Privacy Policy for additional information). Excluded from consent requirements are such activities as quality assurance reviews by your insurance company's credentialing and quality departments. You have the right to request restriction of uses and disclosure of your protected health information but submitting this request in writing. The Oak Bower will inform you of whether your provider agrees to this request.

Appointment Cancellation, No-Show, and Disengagement Policy for All Patients

Please give us at least 24 hours' notice if you will be unable to make an appointment with The Oak Bower, as we make an effort to maximize our availability to patients awaiting care. If you provide less than 24 hours' notice, we will designate the appointment as a "no-show." If you have not arrived by 15 minutes after the scheduled start of your appointment time, we will designate the appointment as a "no-show." The fee for a no-show is $50. This fee is **not** covered by your insurance company and will be billed directly to the credit card you have provided on file. If no-shows become a pattern, your provider may speak to you about whether continuing treatment makes sense for you at this time. If your provider has not heard from you for 30 or more days, your case will be closed. If you decide to reengage, you may have to be entered onto the waitlist. Case closure does not limit you from receiving future services with any mental health professional.

Telephone Communication

Face-to-face treatment is the preferred method of communication. Telephone/videoconferencing consultations are considered on a case-by case basis.

Electronic Communication

You may have access to your provider's email address via business cards, websites, etc. This email is **not** to be used for clinical concerns and should **only** be used for brief, non-sensitive updates, such as canceling appointments. Do **not** email your provider regarding the content of your MH sessions. Use of this method of communication is conducted at your own risk, as The Oak Bower cannot assure the privacy, protection, or integrity of this form of communication. Emails sent to your provider become part of your legal MH record. Additionally, your provider may occasionally use a fax machine to transmit records (e.g., when you request that your primary care doctor receive updates). Your provider will take every reasonable precaution to protect your privacy, following all regulations and guidance outline by the Health Insurance Portability and Accountability Act of 1996

(HIPAA, Public Law 104-191), when using this form of communication, but your provider cannot guarantee the privacy practices of the recipient of the faxed document.

Internet and Social Media Policy

Your provider does not knowingly accept friend or contact requests from current or former patients on any social networking site, as these internet contacts can compromise your confidentiality, erode the privacy of your provider, and blur the boundaries of the therapeutic relationship. Do not use text messaging or messaging on social networking sites in an attempt to contact your provider. Recommendations of software or app based technology for therapeutic purposes will be made with the patient's best interests in mind, in hopes of directing you to helpful, trustworthy resources. However, The Oak Bower cannot endorse, approve, or guarantee software, information, products, or services provided by or at a third-party resources, or track changes in the resource. The Oak Bower is not responsible for the content or accuracy of any third-party resource, potential confidentiality breeches incurred through the use of, or for any loss or damage that may result from the use of, or for any failure of, products or services provided at or from a third party resource. Use of a third party resource subjects you to the terms and licenses of the third party resource, and you are no longer protected by the privacy policy, confidentiality, and security practices of The Oak Bower. You should familiarize yourself with any license or use terms of, and the privacy policy and security practices of the third party resource which will govern you use of that resource. If any product recommendations are made, Dr. McEachern will inform you of any potential conflict of interest, to include financial disclosures, if they are in existence at the time the recommendation is made.

Surveillance: Video camera surveillance is used in the waiting area of the clinic for safety and security purposes, as well as to alert providers of the arrival of patients in the absence of receptionist services. Video surveillance is only accessible by Dr. McEachern and the other mental health professionals leasing space within the suite. Surveillance equipment will never be placed in private spaces, such as bathrooms or offices. The camera runs continuously, 24 hours per day, seven days a week. Recordings are encrypted and stored for a brief period of time before they are permanently erased. In the event that recorded materials may need to be used in the service of an investigation (e.g., theft, assault, other reportable incident), your privacy as a patient may be compromised. If recorded material is ever used in the reporting and/or investigation of an incident, documentation of the viewer's credentials will be made. All patients visible in the recorded segments will be notified of their presence in the video and will be provided the name of all persons who viewed the recording in conducting the investigation. No other video or audio recordings will occur in session without the expressed permission of the patient AND your provider.

Revocation of Consent

You have the right to revoke this consent in writing. However, actions taken by The Oak Bower prior to revocation of the consent are not subject to the revocation.

Special Notes for Military Members

Despite The Oak Bower's specialty in providing MH services to military members, The Oak Bower providers are not agents or employees of the DoD or federal government. Thus, the only disclosures made to your chain of command will be those expressly outlined in the Privacy Act and/or those you have authorized. Note: Since The Oak Bower is not an entity of the DoD or federal government, your provider does not have the capability of issuing DLCs/profiles or writing NARSUMs for MEBs.

If you have any questions or concerns about the information and instructions contained herein, speak to your provider immediately.

By signing below, I affirm that I have read the policy above and voluntarily consent to evaluation and or treatment with understanding of the limitations of my privacy.

Printed Name: _____ Signature: _____ Date: _____

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Patient Background Information Questionnaire

1. General Patient Information

Today's Date: (MM/DD/YYYY)	DOB: (MM/DD/YYYY)		Age:	
Patient Name:	Gender:		Ethnicity:	
Street Address:			Social Security Number:	
City, State, Zip Code:				
Home/Cell Phone:	Can a voicemail from Dr. McEachern be left on this phone? ☐Yes ☐No	Work Phone:	Can a voicemail from Dr. McEachern be left on this phone? ☐ Yes ☐No	
Email:			Can Dr. McEachern email you? ☐Yes ☐No *(Email is not considered a confidential form of communication-see Informed Consent.)*	
List any concerns you have about confidentiality/privacy/your patient rights:			Do you feel coerced in any way to be here? ☐Yes ☐No If so, please explain:	
Who referred you to Dr. McEachern?			If no one referred you, how did you learn about Dr. McEachern?	
Emergency Contact Name:		Relationship to you:	Emergency Contact Number(s):	

2. Insurance Information

Please select your preference ☐ Private pay only *(skip to 3. Primary Concern/Problem)*
☐ Private pay and will submit to insurance for reimbursement (skip to 3. Primary Concern/Problem)
☐Submit to insurance *(please continue)*

Note: The patient is responsible for assuring that services provided by Dr. McEachern are covered, as well as deductibles and co-payments.

If TRICARE

Name of Sponsor	Relationship to Sponsor	Sponsor Social or Patient DBN	CoPay amount

All other insurance carriers

Insurance Carrier	Name of Insured Person	Relationship to Insured	Group ID	Member ID	CoPay amount

3. Primary Concern/Problem

Describe the primary concern/problem that brought you here:

How long have you been experiencing this concern/problem?

What led to your decision to seek help now?

In a single word, describe your mood over the past 2 weeks:

	Yes	No
Are you currently feeling helpless or hopeless? If so, please describe:	☐	☐
Over the past week, have you had thoughts of killing yourself? *If so,* do you intend to kill yourself? Y/N When? How?	☐	☐
Over the past week, have you had thoughts of killing someone else? *If so,* do you intend to harm someone? Y/N Who? When? How?	☐	☐

If you currently own or plan to acquire a firearm, is/will the weapon be secured?	Yes ☐	No ☐

4. Mental Health History

Have you *ever* received counseling or other mental health/substance abuse treatment? If yes, please describe:	Yes ☐	No ☐
Have you *ever* been hospitalized for psychiatric reasons? If yes, please describe:	Yes ☐	No ☐
Have you *ever* been prescribed medications to change your mood, thoughts, behaviors, or sleep? If yes, please list names & timeframes of medications:	Yes ☐	No ☐
Are you currently under the care of a psychiatrist or prescribing provider? If yes, please write the name of your provider:	Yes ☐	No ☐
Does anyone in your family have a history of substance abuse, depression, or any other mental health condition? If yes, please describe:	Yes ☐	No ☐
Have you *ever* intentionally tried to kill yourself?	Yes ☐	No ☐
Have you *ever* intentionally cut, burned, or otherwise harmed yourself?	Yes ☐	No ☐
Has anyone close to you ever completed suicide?	Yes ☐	No ☐

5. Medical History

Who is your primary care provider (e.g., PCM, PCP, family doctor)?		
Please list and date any prior surgeries:		
Do you have any serious and/or chronic medical diagnoses? If yes, please list:	Yes ☐	No ☐
Are you currently taking any prescription, over the counter, supplements, or herbal medicines? If yes, please list:	Yes ☐	No ☐
Do you have any food or drug allergies? If yes, please list:	Yes ☐	No ☐
Are you currently experiencing any chronic pain? If yes, where? Please rate this pain on the following scale: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable Pain)	Yes ☐	No ☐

6. Personal and Social History

Where were you born?	Where were you raised?		
Who were you raised by?	Number of Siblings:	Birth Order Number (e.g., 3rd):	
Are your parents divorced? ☐Yes ☐No If yes, how old were you?	Were you adopted or placed in foster care? ☐Yes ☐No If so, at what age?	Were you ever considered developmentally delayed? ☐Yes ☐No If so, please describe:	
Have you experienced any significant social problems? If yes, please describe:		Yes ☐	No ☐
Have you *ever* experienced a traumatic event? If yes, please describe:		Yes ☐	No ☐
Have you *ever* had legal or financial problems?		Yes	No

If yes, please describe:	☐	☐

7. Immediate Family *(may not apply to minors)*

Are you married? ☐Yes ☐No ☐Separated ☐Divorced	How many total times have you been married?
Have you had a spouse precede you in death? ☐Yes ☐No If so, when?	If married, spouse's name and age:
If not married, are you currently in a relationship? ☐Yes ☐No –if no, skip to children section	Length of current marriage or relationship:

How would you rate your overall satisfaction with your marriage/relationship?
(Very Unsatisfied) 1 2 3 4 5 (Very Satisfied)

Please rank how your relationship impacts your described symptoms:
(Worsens symptoms) 1 2 3 4 5 6 7 8 9 10 (Alleviates symptoms)
(no impact)

If you have children, please list them below:

Child's Name	Age	Special Needs, if any:	Gender		Living with You?		Is this your stepchild?	
			M	F	Yes ☐	No ☐	Yes ☐	No ☐
			M	F	Yes ☐	No ☐	Yes ☐	No ☐
			M	F	Yes ☐	No ☐	Yes ☐	No ☐
			M	F	Yes ☐	No ☐	Yes ☐	No ☐
			M	F	Yes ☐	No ☐	Yes ☐	No ☐
			M	F	Yes ☐	No ☐	Yes ☐	No ☐

If there is anyone else currently living in your home, please list:

8. Group Identities

Do you have any continued involvement in religious or spiritual activities? ☐Yes ☐No
If yes, what is your affiliation?

Do you have any religious practices or concerns that may alter your care? ☐Yes ☐No
If yes, please describe:

Are there any other affiliations or aspects of your identity that are important to your care? ☐Yes ☐No
If yes, please list and/or describe:

9. Education and Occupation

What is the highest level of education you have completed?

If you have completed any college, please list your major(s)/degree(s):

If you had any learning or behavioral problems while in school, please describe:

What is your current job/profession?

How would you rate your overall satisfaction with your current job?
(Very Unsatisfied) 1 2 3 4 5 (Very Satisfied)

Please rank how your work or schooling impacts your described symptoms:
(Worsens symptoms) 1 2 3 4 5 6 7 8 9 10 (Alleviates symptoms)
(no impact)

10. Treatment Goals

Briefly describe things you wish to accomplish during your treatment:
1.
2.
3.

11. Military Service

(Note: If you or your spouse are not in the military and are not military veterans, leave this section blank.)

Are you currently in the military? ☐YES ☐NO If no, are you a military veteran? ☐YES ☐NO *(If yes to either, please complete section 11a.)*	Is your spouse/parent/guardian currently in the military? ☐YES ☐NO If no, is your spouse/parent/guardian a military veteran? ☐YES ☐NO *(If yes to either, please complete section 11b.)*

11a. Military Service Information about Yourself

Branch of Service: ☐ USAF ☐ USA ☐ USN ☐ USMC ☐ USCG ☐ USPHS	Rank/Grade:
Current Duty Status: ☐ Active Duty ☐ Guard ☐ Reserve ☐ Retired ☐ Separated	
Current/Most Recent Unit/Organization:	Duty Title: AFSC/MOS:
Have you been tasked with any deployments? ☐YES ☐NO If yes, list deployment locations and dates:	
Were you sent home early from any deployments for any reason? ☐ N/A ☐YES ☐NO If yes, please describe:	
Have you ever had any disciplinary issues (including PT failures)? ☐YES ☐NO If yes, please describe:	
Have you ever received any notable commendations and/or awards? ☐YES ☐NO If yes, please describe:	

11b. Spouse/Parent/Guardian Military Service Information

If you feel your spouse's military service contributes to your current symptoms/functioning, please describe:

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Financial Agreement and Credit Card Authorization Form

Patient Name: _____Today's Date: _____

I understand that I am responsible for understanding the mental health benefits of my insurance plan and for obtaining the necessary authorizations and referrals. In addition, I agree that my financial responsibilities include the following:

[**Please initial each section and sign at bottom of the document].**

_____ Payment of $50 for missed appointments without 24-hour cancelation notice *(the 24-hours does not include weekends. Cancelations are to be completed **24 business hours** prior to appointment time).* **I understand that my insurance will not cover missed appointments.** This charge is the responsibility of the patient or legal guardian, and must be paid in full before future appointments will be scheduled.

_____ Finance charge of 1.5% for accounts not paid in full within 60 days of the date of service

_____ Service charge of $25 each for returned check, credit card chargebacks, and ACH/electronic bank rejections

_____ Patients paying by insurance:
Co-pays are due at the time of service and will be charged to your credit card on file, unless you provide alternate payment at the time of service.

_____ Patients paying directly and/or patients whose insurance does not cover their mental health claims:
Payment is due at the time of service, at the following rates:

- $275 per initial intake session (45 – 90 minutes)
- $200 per 60 min therapy session (53 – 65 minutes)
- $175 per 45 min therapy session (38 – 52 minutes)
- $125 per 30 min therapy session (16 - 37 minutes)
- $ 250 per hour for psychological testing and comprehensive learning assessments
- $250 per hour for other services such as letters in which clinical information is discussed, communication with other professionals, and services provided by telephone
- Rates for preparation of reports to be used for legal purposes and for Dr. McEachern's attendance at legal proceedings are higher and must be quoted in advance.

_____ The Oak Bower is committed to reducing waste and inefficiency through making our billing process as simple and easy as possible. We require that all patients maintain a valid credit card on file with our office.

Credit Card Type:	□ Visa □ MasterCard □ Discover □ American Express		
Cardholder Name: *(Exactly as it appears on card)*		**Expiration Date:**	
Credit Card Number:		**Security/CV Code on Back of Card:**	
Cardholder Billing Address:			
By signing below, I authorize The Oak Bower, LLC to keep my signature on file and to charge my credit card for services rendered by Amber D. McEachern, Ph.D. (DBA: The Oak Bower, LLC) and other charges (e.g., missed appointments and late cancelations) billed to my credit card according to the fee schedule and policies presented above.			
Cardholder Signature:		**Date:**	

_____ I understand this form is valid for one year, unless I cancel the authorization in writing.
_____ I agree not to dispute charges for sessions I have received or that I have not canceled 24-business-hours prior to a scheduled session. I further authorize The Oak Bower, LLC to disclose information about my attendance/cancelation to my credit card issuer if I dispute the charge.
_____ Past due/overdue accounts will be referred to a collection agency. Legal fees that are paid to secure past due balances will be added to your account. Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling or attending additional appointments.
_____ Informed Consent: I have been provided with, read, and agreed to The Oak Bower's Privacy Policy (*TOB-dPPv2019*) and Informed Consent (*TOB-dICv2019*) prior to signing this document (i.e., Financial Agreement and Credit Card Authorization Form).

_____ _____ _____
Signature of Patient or Legal Guardian | Printed Name of Patient or Legal Guardian | Date