INTEGRAL HEALTH ASSOCIATES

437 Orange Street, New Haven, CT 06511 Tel (203) 909-6370, Fax (203) 909-6374, Alt Fax (203) 777-6776

NEW PATIENT COMPLETE PACKET

Enclosed in this packet are the following forms:

1. Patient Questionnaire
2. Patient Authorization Form*
3. Telehealth Consent Form
4. SMS (Text) Messaging Opt-In Form
5. Magellan Health Member's Rights and Responsibilities Statement
6. Other Information, Policies, Terms, and Conditions**
7. Notice of Privacy Practices**
8. Zoom Instructions**

Please complete forms 1 thru 4 above. Patients with Magellan insurance should also complete form 5. In order for us to verify your identity, please also print a copy of your current driver's license or other photo I.D.

Please mail or fax the above completed paperwork to our address or fax number above.

We may have to reschedule your appointment if the forms are not received at least one week prior to your scheduled appointment.

If your appointment is by Zoom video, please join the meeting using your clinician's Zoom "Personal Link Name" (see attached Zoom instructions). Typically, our clinicians are prompt but on occasion can run up to 15 minutes behind schedule. Please be prepared with make any payment due by credit card or debit card, or contact our office ahead of time if you need other payment options.

Thank you for your prompt attention to the above. We look forward to meeting with you. Please feel free to call us with any questions you may have.

*All patients should sign the first three signature lines on the Patient Authorization Form. You should sign the financial responsibility line even if you expect your insurance company to pay in full, since it is possible that you may incur charges (e.g. paperwork charges or missed appointment). If you have insurance or anticipate having insurance in the future, please be sure to sign the last two signature lines on the Patient Authorization Form. These signatures authorize a) the release of information to your insurance company for insurance processing and b) payment of your medical benefits to us so that we don't have to collect the full amount from you up front. If you are not planning on using insurance, you may leave these two signature lines blank.

** These items are for your information and do not need to be returned to us.

INTEGRAL HEALTH ASSOCIATES

PATIENT QUESTIONNAIRE

Please answer the following questions to the best of your ability. Information will be kept confidential.

Demographic Information:

Last Name: _____ First Name: _____ Middle Name: _____
Date of Birth: _____ Social Security #: _____ Nickname:_____
Gender: Male Female Non-binary Other Email: _____
Marital Status: Single Married Partnered Divorced Widowed Maiden Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Preferred phone (circle one): Home Work Cell OK to leave messages?: Yes No

Employment:

Occupation: _____ Employer: _____ How long? _____
Hours per week: _____ Employer's City and State: _____

Primary Insurance (if applicable) and Information About The Primary Person Insured:

Insurance Company:_____ Employer: _____
Full Name of Primary Person Insured: _____ Date of Birth: _____
Social Security #: _____ Policy (ID) Number: _____
The primary insured person is my (circle one): Self Spouse Child Other: _____

In Case of Emergency Contact:

Name: _____ Relationship: _____ Phone number: _____
Address/City/State/Zip: _____

Other Healthcare Providers:

Name of Primary Physician: _____ Phone number: _____
Address/City/State/Zip: _____

Name of Previous Psychiatrist: _____ Phone number: _____
Address/City/State/Zip: _____

Name of Current/Previous Therapist: _____ Phone number: _____
Address/City/State/Zip: _____

Main Reason for Today's Visit: _____

Psychiatric History:

Have you ever… (Please circle Yes or No, and answer follow-up questions)

Seen a therapist in the past? No Yes Age of first contact: ___
Seen a psychiatrist in the past? No Yes Age of first contact: ___
Been hospitalized for a mental illness? No Yes # hospitalizations: ___
Approximate dates of hospitalizations: _____

Have you ever experienced… (Please circle the appropriate responses)

Panic attacks?	No	In the past	Currently
Life threatening trauma?	No	In the past	Currently
Sexual abuse?	No	In the past	Currently
Physical abuse?	No	In the past	Currently
Depressed mood nearly every day for at least 2 weeks?	No	In the past	Currently
Loss of interest in nearly all activities for at least 2 weeks?	No	In the past	Currently
Thoughts of suicide?	No	In the past	Currently
Intentional cutting or other ways of harming yourself	No	In the past	Currently
Thoughts of harming another person?	No	In the past	Currently
Days or weeks at a time with very little need for sleep?	No	In the past	Currently
Hearing voices that you were not sure were real?	No	In the past	Currently
Seeing things that you were not sure were real?	No	In the past	Currently
Problems with alcohol or street drugs?	No	In the past	Currently
Problems with prescription painkillers or sedatives?	No	In the past	Currently
Problems with gambling?	No	In the past	Currently
Continuous period of excessive risk taking?	No	In the past	Currently
Out-of-control and markedly excessive spending of money?	No	In the past	Currently
An eating disorder?	No	In the past	Currently
Intrusive obsessions that you could not control?	No	In the past	Currently
Compulsions? (e.g. excessive hand washing, checking locks)	No	In the past	Currently

Are you currently experiencing any significant problems with…

Sleep?	No	Yes
Appetite?	No	Yes
Energy?	No	Yes
Concentration?	No	Yes

Use of Substances: Have you ever used the following:

Cigarettes/nicotine?	Yes	No	Last used: _____
Alcohol?	Yes	No	Last used: _____
Marijuana	Yes	No	Last used: _____
Cocaine/crack/speed?	Yes	No	Last used: _____
Heroin/Percocet/Oxycodone/opioids?	Yes	No	Last used: _____
Ecstacy/LSD/mushrooms?	Yes	No	Last used: _____

Medical History: Please list your current and significant past medical problems: _____

_____

_____

Medications: Please list your current medications and doses: _____

_____

_____

_____

Please list any previous psychiatric medications and the reason for stopping them: _____

_____

Please list any allergies to medications: _____

Family History of Mental Illness or Substance Abuse:

Please list any mental illnesses or substance abuse in your family:

Biological Father: _____ Biological Mother: _____

Siblings: _____ Biological Grandparents: _____

Other:

Place of birth: _____ Siblings and their ages: _____

Father's occupation: _____ Mother's occupation: _____

Current living situation (e.g. house, condo, apt, group home, shelter, homeless): _____

Who lives with you? _____

Highest level of education: _____

Primary support system (e.g. friend(s), spouse, none):_____

Is religion an important part of your daily life? Yes No

Do you attend religious services regularly? Yes No

Please list any activities or hobbies you enjoy: _____

Have you ever been arrested? Yes No

Do you have any current legal problems? Yes No

Do you currently have substantial worries about your…

Finances?	Yes	No	Housing?	Yes	No
Job?	Yes	No	Health?	Yes	No
Relationship(s)?	Yes	No	Insurance?	Yes	No

Other worries: _____

Height: _____ Current weight (best guess):_____ Recent changes in weight? None Up Down

Please circle any of the following physical systems or symptoms that are problematic:

Fever or weight loss	Musculoskeletal (e.g. back pain, joint pain)
Eyes	Skin or breast
Ears/nose/throat	Neurological (e.g. headache, seizures)
Cardiovascular	Endocrine (hormones)
Respiratory	Blood or lymph system
Gastrointestinal	Allergic reactions or immune problems
Genitourinary	Other physical complaints: _____

Any other information you would like us to know? _____

_____

I certify that the above information provided is true to the best of my knowledge.

Print name: _____ Signature: _____ Date: _____

INTEGRAL HEALTH ASSOCIATES

PATIENT AUTHORIZATION FORM

AGREEMENT TO RECEIVE TREATMENT

I, (name of patient) _____, consent to participate in behavioral health care services offered and provided by Integral Health Associates. I have read the "Other Information, Policies, Terms, and Conditions" document and understand and accept the contents therein. This document is included in our online and mailed New Patient Packet, and available on our website (www.integralhealthct.com).

_____ _____

Signature of patient or legal guardian* Date

*If the patient is under the age of 18 or is unable to consent to treatment, I, (name of legal guardian) _____, attest that I have legal custody of this individual and/or am legally authorized to initiate and consent to treatment on behalf of this individual.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read, been shown, or given a copy of the Notice of Privacy Practices of Integral Health Associates. This notice is posted in our waiting rooms, included in our online and mailed New Patient Packet, and available on our website (www.integralhealthct.com).

_____ _____

Signature of patient or legal guardian Date

FINANCIAL RESPONSIBILITY

I hereby agree to pay all charges for services provided by Integral Health Associates for the treatment of (name of patient) _____. I agree to be personally responsible for such charges, including any fees associated for late cancellations, missed appointments, late payments, interest charges, and billable paperwork. Furthermore, I agree that if my account defaults because of my failure to pay the balance due, I will be financially responsible for compensating Integral Health Associates for the cost of payment collection, including collections agency and/or attorney fees and court costs permitted by law.

_____ _____

Signature of financially responsible party Date

RELEASE OF INFORMATION FOR INSURANCE PROCESSING

I hereby authorize Integral Health Associates to release medical information about me to my insurance company or managed care company for the purpose of documenting medical necessity and appropriateness of treatment, and for processing insurance claims.

_____ _____

Signature of patient or legal guardian Date

AUTHORIZATION OF PAYMENT OF MEDICAL BENEFITS

I hereby authorize my insurance company or managed care company to pay my health insurance benefits directly to Integral Health Associates for any treatment provided.

_____ _____

Signature of patient or legal guardian Date

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TELEHEALTH CONSENT FORM

This consent and acknowledgment form covers the use of telehealth by Integral Health Associates.

Within this document, "telehealth" includes communication forms such as telephone, cellular phone, and audio-video that occur over information networks rather than in person face-to-face. "Integral Health Associates" (herein referred to as "IHA") includes the business entity known as such in the State of Connecticut and clinical providers contracted by the entity.

By signing this form, I am indicating that I understand and am in agreement with the following:

1. Engagement in telehealth by myself and IHA is completely voluntary. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. IHA has the right to offer or cease the offering of telehealth for any reason not specifically excluded by law.

2. IHA will not disseminate any personally identifiable information obtained through the use of telehealth to other entities without my consent.

3. Medical documentation of telehealth sessions by IHA will occur based on generally accepted standards, but Integral Health Associates will not voluntarily record or allow recordings of any part of any telehealth session. Likewise, I agree not to make or allow recordings of any part of any telehealth session.

4. Despite reasonable efforts by IHA, there are risks and possible consequences from telehealth including, but not limited to, possible disruption of the transmission of my health information by technical failures, possible access and misuse of my health information by unauthorized persons, and the possibility that telehealth services may not be as complete or effective as face-to-face services.

5. Services provided by IHA through telehealth services are professional services that may or may not be covered by insurance companies. IHA may be able to assist you with filing insurance claims, but ultimately, I am responsible for full payment just as I would be for face-to-face office visits.

6. I agree to be physically within the state of Connecticut and available for telehealth sessions at the time of my appointments. This includes having the ringer on for telephone appointments, logging in for video appointments, and being in a quiet, private location with reliable telephone, cellular, wifi, or ethernet connectivity as needed.

7. Missed appointments will be charged the same as missed face-to-face sessions according to office policy. If I am available and my provider does not contact me within 15 minutes of a scheduled telehealth session, I am free to move on to other activity without being charged for a missed appointment.

8. If a telehealth session is interrupted due to a technical problem, I agree to immediately make reasonable attempts to reconnect or contact my provider through some other means if available.

I hereby acknowledge my understanding of the above items, indicate my agreement to them, and consent to the use of telehealth as part of my overall treatment provided by Integral Health Associates.

Name of patient (print): _____ Date of birth: _____

Signature of patient (or legal guardian if patient is under 18 years old): _____

Name of legal guardian if patient is under 18 years old (print): _____

Date Signed: _____

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SMS (TEXT) MESSAGING OPT-IN FORM

I hereby consent to receive SMS (text) messages from Integral Health Associates for appointment reminders, scheduling changes, account notifications, and other similar information. I understand that texting may not be completely secure and that Integral Health Associates may opt to not communicate by text. I further understand that this consent in no way indicates that Integral Health Associates will utilize SMS texting as an appropriate or reliable means for me to communicate with them other than by responding to a text I receive with one of the provided response options. I have read and agree to the SMS Terms and Conditions (included in our online and mailed New Patient Packet, available on our website at www.integralhealthct.com, and copied below).

Name of patient (print): _____ Date of birth: _____

Signature of patient (or legal guardian if patient is under 18 years old): _____

Name of legal guardian if patient is under 18 years old (print): _____

Date Signed: _____

SMS - Terms and Conditions

With your permission via an opt-in, we [Integral Health Associates] may communicate with you via SMS (texting) for non-clinical issues such as appointment reminders, weather-related closures, or account notifications. SMS is not considered fully secure. By opting in to SMS from a web-based form or other medium, you are agreeing to receive SMS messages from Integral Health Associates. Message frequency may vary, and message and data rates may apply. Per our privacy policy (http://www.integralhealthct.com/nopp), we do not sell or give out your opt-in status. Once opted-in, you may reply STOP to any message to opt out, or message HELP for help regarding our SMS texting opt-in or opt-out process.

MAGELLAN HEALTH
MEMBERS' RIGHTS AND RESPONSIBILITIES STATEMENT

Statement of Members' Rights

Members have the right to:

- Be treated with dignity and respect.
- Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept confidential. Only where permitted by law may records be released without the member's permission.
- Easily access care in a timely fashion.
- Know about their treatment choices. This is regardless of cost or coverage by their benefit plan.
- Share in developing their plan of care.
- Receive information in a language they can understand, and free of charge.
- Receive a clear explanation of their condition and treatment options.
- Receive information about Magellan, its providers, programs, services and role in the treatment process.
- Receive information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Members' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- If asked, Magellan will act on the member's behalf as an advocate.*
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Request certain preferences in a provider.
- Have provider decisions about their care made on the basis of treatment needs.
- Receive information about Magellan's staff qualifications and any organization Magellan has contracted with to provide services.*
- Decline participation or withdraw from programs and services.*
- Know which staff members are responsible for managing their services and from whom to request a change in services.*

Statement of Members' Responsibilities

Members have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers and Magellan information that they need. This is so providers can deliver quality care and Magellan can deliver appropriate services.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider(s) as soon they know they need to cancel visits.
- Let their provider know when the treatment plan is not working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.
- Let Magellan and their provider know if they decide to withdraw from the program.*

* This standard is required for our *Condition Care Management* (CCM) products.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

_____

Member Signature Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

_____

Provider Signature Date

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OTHER INFORMATION, POLICIES, TERMS, AND CONDITIONS

Fees/Insurance

If we are currently a provider in your health care plan's network, we have agreed to accept the fee schedule set by your plan and will handle the insurance billing as a courtesy. Please be aware that you may have a co-payment for each visit and/or a yearly deductible. There may also be a yearly maximum on either the number of visits or the amount paid for psychiatric services.

If you do not have insurance coverage, or have an insurance plan for which we are not in network, you will be charged in full for services provided. If you have out-of-network benefits, you may be eligible for reimbursement directly from your insurance company. In some cases, our billing staff may be able to submit an out-of-network insurance claim on your behalf as a courtesy. At the very least, we can provide you with an invoice that may be used to file a claim yourself. Feel free to ask any questions you may have about filing out-of-network claims.

Fees for non-covered services may be applicable in some circumstances (see Cancellations and Missed Appointments and Requests for Paperwork below).

You will be responsible for all charges that are not covered by your health insurance, even in the event that your insurance company does not pay as you or we anticipated. We recommend that you check your health insurance coverage for outpatient mental health care and review your coverage regularly and with any change in status (e.g. employment change of the primary insurance holder, change in student or marital status, aging out of coverage through parents). It is your responsibility to communicate any changes in your health insurance coverage to us in a timely manner to avoid insurance non-payment due to late filing of claims. We will help you as best we can, but your insurance company or employer is the best source for information for matters pertaining to coverage.

Payments

Payments (including insurance copays and full charges for visits when not using insurance for which we are in-network) are due at the time of the appointment and may be made by cash, check, or credit/debit card. There is a $5 processing fee for not having your payment at the time of the visit, a $30 fee for checks returned for insufficient funds, and a 1.5% per month interest charge on balances greater than 60 days past due. To avoid penalties for late payment, we encourage patients to keep a valid credit or debit card on file with us.

Cancellations and Missed Appointments

There is no charge if you cancel an appointment at least 24 hours in advance. There is a $25 fee for each Late Cancellation (canceling an appointment with less than 24 hours notice), and a $75 fee for each Missed Appointment (failure to show up for an in-person appointment, failure to answer the phone for a telephone appointment, or being unavailable through our video portal for a video appointment). These fees are not usually covered by insurance.

Arriving Late

If you present late for an appointment, we will generally make a reasonable attempt to keep the appointment, but priority will be given to patients who are on time, and you may be billed for a Missed Appointment if we end up unable to connect after your late arrival.

Phone Calls and Messages

When responding to your phone message, we may call you back at the number you called from or the number that we have listed for you in our computer system. If you do not want us to leave a return voicemail message for privacy reasons at either of these numbers, please indicate so on your message.

Routine calls for clarification, scheduling, refills, and other simple matters will generally be brief and made as a courtesy. However, if a phone call with one of our providers involves clinical assessment, discussion of treatment options, psychotherapy, and/or medical decision-making, it is likely that the call will be considered a clinical visit and may generate usual fees. Be aware that insurance companies may not cover telephone visits, in which case you may be fully responsible for charges related to such calls. If you are concerned about the possibility of being charged for a telephone visit, please discuss this with your provider at the start of the call or request an appointment in person or via our video platform

SMS - Terms and Conditions

With your permission via an opt-in, we may communicate with you via SMS (texting) for non-clinical issues such as appointment reminders, weather-related closures, or account notifications. SMS is not considered fully secure. By opting in to SMS from a web-based form or other medium, you are agreeing to receive SMS messages from Integral Health Associates. Message frequency may vary, and message and data rates may apply. Per our privacy policy (http://www.integralhealthct.com/nopp), we do not sell or give out your opt-in status. Once opted-in, you may reply STOP to any message to opt out, or message HELP for help regarding our SMS texting opt-in or opt-out process.

Communicating by SMS/Email is Not Fully Secure

At this time, we do not subscribe to an encrypted, fully secure two-way text messaging or email system. Thus, we do not normally monitor or respond to text or email messages. Preferred methods of communication are in-person, video, telephone, fax, or regular mail.

Requests for Paperwork

We will generally handle all routine paperwork directly related to provision of your clinical care. For special requests such as preparation of documents related to disability, there may be a charge for time spent. Please be advised that in general, we do not provide disability forms or medico-legal statements until we have made a full objective assessment, a process that may take more than one visit.

Prescriptions

If we prescribe medication to you, it is important that you do not change your dose or stop taking your medication without discussion with us ahead of time. Please contact us if you are considering making a change. Also, please monitor your supply and call us at least one week before running our of medication, or three weeks before running out if you are using a mail-order pharmacy. Although we generally try to respond to pharmacy “auto-refill” requests, these may not always accurately reflect your actual supply of medications.

Medications can sometimes pose serious risks in certain combinations or in pregnancy. It is very important that you inform your prescribing clinicians if there is any change in your medications or if you are considering pregnancy or become pregnant.

Emergencies

In the event of a mental health emergency, please contact us or go to a nearby emergency room. Mental illness can sometimes cause impaired judgment and/or thoughts of hurting oneself or someone else. In these cases, it is extremely important for you to get the help you need. In some cases, as with other medical illnesses, appropriate care may include hospitalization. Please be aware that although it is possible that you may be hospitalized against your will for your own safety or the safety of others, this is sometimes a necessary step in the road to recovery.

Discontinuation of Treatment

We will usually discontinue treatment with a patient only after considerable discussion and usually for one of the following reasons: (1) not paying the bill or responding to our attempts to work out an arrangement, (2) canceling too often, (3) not following through with treatment recommendations. If you foresee a problem in any of these areas, please let us know. If we see difficulty in any of these areas, we will generally bring it up with you so we can discuss it.

You can discontinue treatment with us at any time in person, by phone or video, or in writing. We are not easily offended if you want to end your treatment with us, and you can usually reopen your case simply by calling us if you ended the treatment in good standing or if you have made changes that will allow the treatment to go forward again.

Other Issues

Hopefully, these policies will make our interactions easier, but sometimes there are unplanned issues. We will be honest and do our best to be fair while being consistent. Please bring to our attention any questions or concerns you may have about any aspect of your treatment. Due to time constraints, it would be best to bring up any special requests or issues that require immediate attention at the beginning of the appointment. We consider it a privilege to work with you, and look forward to helping you with your health and well-being.

The above information, policies, terms, and conditions are not necessarily complete and are subject to change at any time.

Rev 2/2025

INTEGRAL HEALTH ASSOCIATES

NOTICE OF PRIVACY PRACTICES

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA):

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

Our Commitment To You

We understand that medical information about you and your health is personal. We create a record of care and services that you receive in our office. We need this record to provide you with quality care and to comply with certain legal requirements. Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the new revised Notice of Privacy Practices by posting a copy, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

How We May Use and Disclose Health Information About You

For Treatment: Your PHI may be used by and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employees review activities, licensing, and conducting or arranging for other business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law: Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department).
- Required by court order.
- Necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public

Verbal Permission: We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Short Message Service (SMS) We may, upon your opting-in, send you SMS messages for appointment reminders, scheduling changes, account notices, and other similar notifications. You may opt-out at any time by replying to any SMS message with "STOP". We do not share or sell phone numbers or SMS opt-in information for marketing purposes.

Your Rights Regarding Your Personal Health Information

You have the following rights regarding PHI we maintain about you. To exercise any of these rights submit your request in writing to our office.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restriction.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree with your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Complaints

If you believe we have violated your privacy rights, you have the right to file a complaint in writing to our office at the above address, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, DC 20201 or by calling (202) 619-0257. We will not penalize you for filing a complaint.

The effective date of this Notice is February 1, 2025.

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ZOOM INSTRUCTIONS

(Updated March 13, 2025)

Our practice uses a medical-grade, HIPAA-compliant version of Zoom. This version has increased privacy and security compared to the free version. It can be accessed from any browser on a computer with a microphone and camera, or from the Zoom app on any other mobile device including a smartphone or tablet. The Zoom app is free and you do not need to create your own account to use it.

To start a video appointment with your clinician, from the Zoom website or app, simply enter your clinician's "Personal Link Name" at the time of your appointment.

The Personal Link Names of our clinicians are:

Richard Yun, M.D.	dryun.integral
Amy Catalano, Psy.D.	drcatalano.integral
André Philipp, A.P.R.N.	andre.integral
Goetti Francois, A.P.R.N.	goetti.integral
Kate Pfeiffer, A.P.R.N.	kate.integral
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