Ben Novell, MS, LMFT, LPCC
Marriage and Family Therapist
State License MFC25733

Janelle K. Novell, MA, LMFT, RPT-S
Marriage and Family Therapist
State License MFC32101

Client Information Form

Client Name	Address
First: Last:	Street: City: State: Zip:

Check box for preferred call number

☐ Home Phone	☐ Cell Phone	☐ Work Phone	Email Address
( )	( )	( )	

DOB	SSN	Driver's License #

Marital/Relationship Status	How long in current relationship?

Occupation	Employer/ School
Employer/ School Address	
Street: City: State: Zip:	
How long at current employer?	

Insurance
Insurance Address
Street: City: State: Zip:

List all family members living in your home	Age

Client Information Form (cont'd.)

Reason you are seeking counseling?

If you were referred here, who referred you?

Have you ever been seen by a Psychiatrist, Psychologist or Counselor?		
Yes (☐) No (☐) If Yes:		
Who?	**When?**	**Where?**
For What Reason?		

In Case of Emergency Contact	Address		
First: Last:	Street: City:	State:	Zip:
Relationship	**Home Phone**	**Cell Phone**	**Work Phone**
	( )	( )	( )

Responsible Party

(If Client is a Minor or has Conservator)

Name	Address		
First: Last:	Street: City:	State:	Zip:
Check box for preferred call number			
☐ Home Phone	☐ Cell Phone	☐ Work Phone	Email Address
( )	( )	( )	

DOB	SSN	Drivers License #

Occupation	Employer

Employers Address
Street: City: State: Zip:

Signature	Date

Client Information Form (cont'd.)

Additional Responsible Party

Name	Address
First: Last:	Street: City: State: Zip:

Check box for preferred call number

☐ Home Phone	☐ Cell Phone	☐ Work Phone	Email Address
( )	( )	( )	

DOB	SSN	Drivers License #

Occupation	Employer

Employers Address
Street: City: State: Zip:

Signature	Date

County Of Riverside
Department of Mental Health

Registration Sheet

Name: _____ _____
First Last

Address: _____

City: _____ State: ____ Zip: _____

Phone Number: (__) _____

Social Security Number: _____

Age: ____

Date of Birth: _____

Birthplace: _____ _____
City State

Race: _____

Marital Status: _____

Primary Language: _____

Riverside University Health System – Behavioral Health

Adult Consent for Treatment

I, _____, consent and agree voluntarily to receive psychological services from Novell & Novell Counseling Services, Inc., on behalf of Riverside University Health System – Behavioral Health. These services may include, but are not limited to, diagnostic assessments; psychological testing; crisis intervention; individual, group, and/or family therapy; and consultations and referrals to other behavioral health professionals.

I understand that by consenting to treatment, personal health information may be exchanged in a limited way for treatment, payment and healthcare operations purposes, only.

I understand that I have the right to terminate treatment at any time. I also understand that I have the right to refuse to implement any recommendations, psychological interventions, or any treatment procedure.

I understand that I am expected to benefit from treatment, but there is no implied or expressed guarantee that I will.

_____ _____

Consumer or Legal Representative's Signature Date

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General Client Information

We appreciate your interest in seeking professional help. We believe that a clear understanding of the practical aspects of your relationship with us, at the onset of treatment is in the best interest of therapy. It is with this in mind that we present the following information to you.

- THERAPY consists of face-to-face contacts between a qualified professional and the person(s) in treatment. The focus is on the present problem and associated feelings, assessing possible causes of the problem and possible alternative courses of action and their consequences. The frequency and type of treatment will be decided upon between you and your therapist. You are expected to benefit from therapy, but there is no guarantee that you will. Maximum benefits will occur with regular attendance, but you may feel temporarily worse while in treatment.

- NOVELL AND NOVELL COUNSELING SERVICE FEE SCHEDULE IS AS FOLLOWS:
    - The standard fee for counseling services is **$150.00 per clinical session**. Occasionally, there is a need that requires the services of two therapists. The fee for this service is **$300.00 per session. Clients are expected to pay for the service at the time the service is rendered, unless other arrangements have been made in advance with the administrator**. If you are in financial need we encourage you to discuss this with the administrator.
    - When there is a need for a **written report**, you will be billed at a rate of **$100.00 per page**. Generally, **there will be no charge for correspondence of one page or less**. In the event that correspondence of lengthy duration is required, you will be billed at the rate of $50.00 per page.
    - Occasionally, a need to communicate with your therapist may arise between sessions. No charge will be made for contact less than 10 minutes. **Contact in excess of 10 minutes will be prorated at the rate of $150.00 per hour.** (Contact includes telephone, faxing and any electronic forms of communication).
    - **If you do not keep an appointment or do not cancel at least 24 hours in advance, you will be charged $50.00 for your reserved time.** Adhering to this policy will be helpful for other clients and allow your therapist to make more efficient use of available time. We understand that emergencies do happen and we will take this into consideration.
    - **Payment is required at the time of service. We accept Master Card, Visa, debit cards and cash. A 15% APR service charge will be added to accounts that carry a balance. We do not accept checks.**

Initial Here _____

- INSURANCE REIMBURSEMENT:
    - Many insurance companies do reimburse for therapeutic treatment. If you have insurance we are willing to process forms for you. However, **until your insurance coverage is verified, you will be expected to pay for services at the time service is rendered**.
    - You must also understand that if you have insurance coverage, you are still responsible for payment of the bill. This will include any deductibles or any amounts unpaid by the insurance coverage unless otherwise contractually agreed upon between therapist and Insurance Company.
    - Since many insurance companies will pay only a portion of treatment, a co-payment will be required and sometimes a deductible must be satisfied and is your responsibility. Payment is required at the time of service.
    - If you have any questions regarding your financial responsibility, please speak with the billing manager or the administrator. We are interested in your success in treatment and are aware that this issue may become a source of conflict if not resolved prior to counseling.

Initial Here _____

General Client Information (cont'd)

- CONFIDENTIALITY RIGHTS:
  - This is intended to inform you that, by law and by ethical standards, you are guaranteed confidentiality of your communication. Only if permission is given in writing will information be released. However by law, the following exceptions do exist:
  - If you have intentions of harming yourself or another person.
  - If you commit an act of abuse against a child.
  - You may be reported for any criminal acts of violence and elder abuse.

Initial Here _____

- COMFORT OF CLIENTS AND GENERAL RULES:
  - For the comfort of other clients, it is important that your children be under your control. Please supervise your children for their safety and comfort of others.
  - Please, **NO** food or drink in the lobby. Please refrain from smoking in or near the office building for the comfort of all.
  - This is a non-smoking facility. Smoking is not permitted anywhere on the property inside and outside of the building including the parking lot.
  - Please wait in the lobby for your therapist. Do not walk past the receptionist window without assistance. This is important for client confidentiality and respect for other client's time with their therapist. If we are running behind please be assured that you will receive equal time and attention.
  - Please check in at the window upon arrival. Not checking in may result in a delay of your session due to the therapist not being notified of your arrival.
  - We are interested in your feedback. Please go to our website at http://novellcounseling.org to complete our satisfaction survey.

Initial Here _____

- EMERGENCY INFORMATION:
  - In the event of an emergency, **please call 911**.

Initial Here _____

We hope that your relationship with us is helpful and profitable to you. If you have any further questions regarding these arrangements or other aspects of your relationship with us, please do not hesitate to discuss them with us.

I HAVE READ THE ABOVE AND I AGREE TO ACCEPT TREATMENT. FURTHER, I AGREE TO ALL CONDITIONS SET FORTH AND UNDERSTAND MY RESPONSIBILITY. I ALSO GIVE MY CONSENT FOR ANY PSYCHOLOGICAL TESTING NECESSARY IN THE COURSE OF TREATMENT.

_____ _____

Client or Responsible Party Date

Riverside University Health System – Behavioral Health
ADULT MEDICAL HISTORY SUMMARY

Part I – TO BE COMPLETED BY PATIENT OR PATIENT INFORMANT (Please Print)

Patient's Name: _____
(First) (Middle) (Last) (Maiden)

Name of Informant if other than Patient/Relationship: _____

Current Physician: _____
(Name) (Address/City)

Date of Last Physical: _____ **Do you have allergies?** ☐Yes ☐No

PLEASE CHECK ALL OF THE FOLLOWING WHICH YOU HAVE HAD IN THE PAST:

☐Heart Problems	☐Drug Use	☐Liver Problems
☐Shortness of Breath	☐Cancer/Immune Disease	☐Hepatitis/Jaundice
☐Pain/Pressure in Chest	☐Frequent/Severe Headache	☐Diabetes
☐High Blood Pressure	☐Head Injury	☐Tuberculosis (TB)
☐Stomach Problems	☐Stroke	☐Sexually Transmitted Disease
☐Alcohol Use	☐Epilepsy/Convulsions	☐Asthma/Hay Fever/Hives/Rash
☐Dizziness/Fainting	☐Kidney Problems	☐Bedwetting/Soiling
☐Seizures	☐Thyroid Problems	☐Unusual Bleeding
☐PMS/Hormone	☐Therapy	☐Pregnancy

OTHER SERIOUS ILLNESS AND/OR MEDICAL TESTS: _____

_____

_____

SUBSTANCES YOU ARE ALLERGIC TO: _____

_____

_____

DESCRIPTION OF ALLERGIC RESPONSE/NATURE OF REACTION: _____

_____

_____

WITHIN THE PAST YEAR HAVE YOU TAKEN PRESCRIBED OR OTHER MEDICATIONS FOR:

Sleep Disturbance? Name: _____ Currently Using? ☐Yes ☐No

Nutrition/Weight Problem? Name: _____ Currently Using? ☐Yes ☐No

Nerves/Anxiety/Depression? Name: _____ Currently Using? ☐Yes ☐No

Pain? Name: _____ Currently Using? ☐Yes ☐No

Recreation/Relaxation? Name: _____ Currently Using? ☐Yes ☐No

Are you taking, or have you taken Antabuse? ☐Yes ☐No

Consumer Signature: _____ **Date:** _____

Consumer Name:_____

Part II – HISTORY TAKING FOR STAFF USE ONLY (Use Additional Sheets if Necessary)

1. SIGNIFICANT PAST ILLNESS, ACCIDENTS, HOSPITILIZATION, and MEDICAL PROBLEMS:

_____

_____

2. SIGNIFICANT FAMILY HEALTH HISTORY AND PROBLEMS: _____

_____

3. SIGNIFICANT CURRENT MEDICAL PROBLEMS: _____

4. CURRENT PSYCHOTROPIC MEDICATION:

Name	Strength /Dose	Duration of Use

5. PAST PSYCHOTROPIC MEDICATION:

Name	Strength /Dose	Duration of Use	Adverse Reachtions? (Yes/No)
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No

6. OTHER CURRENT MEDICATIONS (Includes Prescription and Non-Prescriptive Drugs):

Name	Strength /Dose	Indication

7. CURRENT USE OF ALCOHOL AND/OR STREET DRUGS:

Name	Frequency Amount

8. PAST USE OF ALCOHOL AND/OR STREET DRUGS:

Name	Frequency Amount

IF ENTRIES ARE MADE TO EITHER QUESTION 7 OR QUESTION 8, PLEASE COMPLETE DRUG/ALCOHOL ASSESSMENT.

COMMENTS: _____

_____

_____

_____ _____
Clinician Signature Date

_____ _____
Reviewing Physician Signature Date

_____ _____
Reviewing Physician Signature Date

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Assignment of Release of Benefits

I hereby authorize my insurance benefits to be paid directly to the provider and acknowledge that I am financially responsible for the non-covered services.

I also authorize the provider to release any information required, to my insurance company in regards to processing my claims and for quality assurance.

_____ _____
Insured and/or client signature Date

_____ _____
Witness Date

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Authorization for Payment of Services

I hereby authorize **Riverside County DMH/DPSS** to pay directly to the provider. I also authorize the provider to release any information required, to **Riverside County DMH/DPSS** in regards to processing my claims and for quality assurance.

_____ _____

Insured and/or Client signature Date

_____ _____

Witness Date

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Consumer Notice Of Rights and Responsibilities

Dignity and Respect

- You have the right to be treated with consideration, dignity and respect – and the responsibility – to respect the rights, property and environment of all physicians and other health care professionals, employees and other patients.
- You have the right to access your own treatment records and have the privacy and the confidentiality of those records maintained.
- You are also entitled to exercise these rights regardless of gender, age, sexual orientation, marital status or culture; or economic, educational or religious background.

Knowledge and Information

- You have the right to receive information about the organization's services and practitioners, clinical guidelines, and members' rights and responsibilities.
- You have the right – and the responsibility – to know about and understand your health care and coverage, including:
    - Participating with your physician and other healthcare professionals in decision making regarding your treatment planning. Having participated and agreed to a treatment plan, you have a responsibility to follow the treatment plan or advise your provider otherwise.
    - The names and titles of all healthcare professionals involved in your treatment.
    - Your clinical condition and health status.
    - Any services and procedures involved in your recommended course of treatment.
    - Any continuing health care requirement following your discharge from a provider's office, hospital, or treatment program.
    - How your health plan operates—as stated in your Policy and/or Certificate.
    - The medications prescribed for you—what they are for, how to take them properly and possible side effects.

Continuous Improvement

- As a partner with your health plan and any health care professional who may be involved in your care, you have the right to:
    - Contact a Member Service Associate to address all questions and concerns as well as to make suggestions for improvement to the health plan and/or the members' rights and responsibilities policies.
    - Ask questions about any clinical advice or prescribed treatment if you need an explanation or want more information.
    - Appeal any unfavorable behavioral health care decisions by following the established appeal or grievance procedures of your health plan.

Consumer Notice Of Rights and Responsibilities (cont'd)

Accountability/Autonomy

- As a partner in your own health care, you have the right to refuse treatment – providing you accept responsibility and the consequences of such a decision – and the right to refuse to participate in any medical research projects.
- You have a responsibility to participate, to the degree possible, in understanding your behavioral health problems and developing mutually agreed-upon goals.
- You also have the responsibility to:
    - Provide your current provider with previous treatment records, if requested, as well as provide accurate and complete medical information to any other health care professionals involved in the course of your treatment.
    - Be on time for all appointments and to notify your provider's office as far in advance as possible if you need to cancel or reschedule an appointment.
    - Receive all non-emergent or urgent care through your assigned behavioral health provider and obtain preauthorization of service from your behavioral health plan.
    - Notify your Behavioral Health Care within 48 hours – or as soon as possible – if you are hospitalized or receive emergency care.
    - Pay all required co-payments and deductibles at the time you receive behavioral health care services.
- You have the right at any and all times to contact a member service associate for assistance with issues regarding your behavioral health plan.
- It is your right to have all the above rights apply to the person you have designated with legal authority to make decisions regarding your health care.

If you have any questions or complaints regarding your rights, contact your Behavioral Healthcare Service Member Associate.

Patient or Guardian's Signature_____ Date_____

Practitioner Signature_____ Date_____

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Policy for Family Therapy and Couple Therapy

This written policy is intended to inform you, the participants in family therapy or couple therapy, that when your therapist agrees to work with a couple or a family, the therapist consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, the therapist will seek the authorization of all members of the treatment unit before release of confidential information to third parties. Also, if records are subpoenaed, the therapist will assert the psychotherapist-patient privilege on behalf of the patient (the treatment unit).

During the course of the therapist work with a couple or a family, the therapist may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that the therapist is doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with the therapist, please understand that generally these sessions are confidential in the sense that the therapist will not release any confidential information to a third party unless the therapist is required by law to do so or unless the therapist has your written authorization. In fact, since these sessions can and should be considered a part of the family or couple therapy, the therapist would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, the therapist may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if the therapist is to effectively serve the unit being treated. The therapist will use his or her best judgment as to whether, when, and to what extent disclosures to the treatment unit will be made, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This policy is intended to allow your therapist to continue to treat the patient (the couple or family unit) by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If the therapist is not free to exercise clinical judgment regarding the need to bring this information to the family or the couple during their therapy, the therapist might be placed in a situation where the therapist would have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We, the members of the _____ (couple/family/partners) being seen, acknowledge by our individual signatures below, that each of us has read the "Policy for Family Therapy and Couple Therapy", that we understand it, and that we enter couple/family therapy in agreement with this policy.

Date:_____ Signature: _____

Date: _____ Signature: _____

Date:_____ Signature: _____

Date: _____ Signature: _____

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Health Care Coordination Form

Consent for Release of Confidential Information to Primary Care Physician (PCP)

Patient Name: _____ DOB: _____ Member ID Number: _____

I hereby authorize the release of medical information listed below which pertains to my medical history, mental or physical condition, or treatment, including information relating to my mental health diagnosis or treatment and/or substance abuse diagnosis and treatment to my primary care physician:

_____

Physician Name Phone Number Fax Number

_____

Address

☐ **Please send to my PCP (Primary Care Physician). I understand that the release of this information is to permit my PCP to monitor my health status and to coordinate all the care, which I may receive from specialists. This authorization becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance hereon. If not earlier revoked, this authorization shall terminate automatically one year from the date of execution. I understand that this authorization is for release of information to my PCP only. Additional information may be provided to this or other recipients only with an additional signed authorization from me. I further understand that I have the right to receive a copy of this authorization upon my request.**

☐ **Do not send to my PCP.**

☐ **I have no current PCP.**

_____ _____

Signature of Patient or Legal Guardian Date

This facsimile transmission contains legally privileged and/or confidential information intended for the parties identified above. If you have received this transmission in error, please notify the sender by telephone and return to Novell & Novell Counseling Services at the address listed below. Distribution, reproduction, or any other use of this transmission by any party other than the intended recipient is strictly prohibited. Disclosure of sensitive information to third parties is prohibited.

Health Care Coordination Form (Cont'd)

THIS SECTION TO BE FILLED OUT ONLY BY NOVELL & NOVELL COUNSELING SERVICES STAFF

Please send completed form to the primary care physician.

In order to coordinate care, I wish to inform you that your patient _____

was referred to me for treatment on ___/___/_____. The DSM-IV diagnoses code is _____.

Outpatient care is being delivered and the treatment plan consists of the following modalities:

- □ Individual Psychotherapy
- □ Couples Psychotherapy
- □ Family Psychotherapy
- □ Group Psychotherapy
- □ Other_____

Medication(s) are being managed by Dr. _____

Medications and Dosages:

1) _____

2) _____

If you need additional information, contact me at **(951) 694-0695.**

Sincerely,

_____ _____

Clinician's Name Signature

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Riverside University Health System – Behavioral Health
Assessment and Consultation Team (ACT)
Authorization Requesting Release/Receipt of Information and/or Records

(Confidential Patient Information – W & I Code Sec. 5328)

Patient's Name: _____ Date of Birth: _____

The Department of Public Social Services has arranged and is partially funding treatment services for you as a part of a service plan through the Juvenile Court. As a part of this process, there is a need to share information between your clinician/provider, Riverside University Health System – Behavioral Health and the Riverside County Department of Public Social Services. This release of information allows for this exchange of information. If you do not wish to sign this authorization, you may still receive confidential services through your own resources. If desired, discuss possible treatment resources with your clinician and, if you wish, with your DPSS social worker.

I, the undersigned, hereby authorize the following to release and exchange information. Please be advised that this authorization allows disclosure as described above and Riverside University Health System – Behavioral Health cannot be held liable for how this information is used by the person/agency to whom the disclosure is made to and their safeguard practices.

Provider: Novell & Novell Counseling Services, Inc. Phone Number: 951-694-0695

Riverside University Health System – Behavioral Health Assessment & Consultation Team
Riverside County Department of Public Social Services

Information may be released with the knowledge that such contact discloses the fact that mental health and/or chemical dependency services have been/are being provided.

This disclosure may include any of the following:
Assessment & Diagnosis
Consumer Care Plan and Discharge Summary
Psychological Testing
Medical, Neurological, Lab Tests, Medications
Progress Reports

This authorization becomes effective _____. This authorization may be revoked by the undersigned at any time, except to the extent that information has already been released. If not revoked, it shall terminate one year from the date of authorization. You have the right to have a copy of this Authorization upon request.

Date: _____ Consumer Signature: _____

☐ Authorization Revoked: _____/_____/_____ Consumer Signature: _____

☐ I refuse all release of information.

Date: _____ Consumer Signature: _____

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Supervision Release

I hereby acknowledge that the counseling services to be received will be performed by a Registered Intern as defined by the State Board of Behavioral Sciences. In addition I acknowledge the Registered Intern is being supervised by a Licensed Marriage, Family, Child Therapist and that this case will be discussed with the supervisor in accordance with the supervision requirements. In addition, group supervision where the case will be discussed on a confidential basis with other Registered Interns present may occur.

Notice of Permission to be Audio & Video Recorded

I am aware that for supervision purposes, sessions may be audio or video recorded.

Audio and video recordings are used for educational and supervision purposes only. Recordings do not become part of the therapeutic record. All recordings are destroyed within 30 days.

_____
Clients Name

_____
Parent, Guardian or Caregiver

_____ _____
Signature Date

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Appointment Reminder Selection

Novell & Novell Counseling Services, Inc. provides for clients to receive courtesy appointment reminders via e-mails, text messages, or telephone calls prior to 24 hours of the scheduled appointment. We have a cancellation policy that requires a 24 hour notice to avoid a $50.00 late cancel or no show fee. The courtesy reminder is intended to prevent this charge from occurring by giving clients a reminder of an upcoming appointment allowing for ample time to cancel or reschedule avoiding this charge.

Disclaimer: It remains the responsibility of the client/caregiver to remember the scheduled appointment date and time and to contact the office to cancel or reschedule an appointment with a minimum of a 24 hour notice. Failure to receive a courtesy reminder or error in the reminder does not eliminate your responsibility to keep your scheduled appointment. If you are unsure about or there appears to be confusion about the appointment, it is your responsibility to contact the office immediately.

There is no charge from Novell & Novell Counseling Services, Inc. for this service, however fees for receiving telephone calls, text messages, or e-mail may apply from your service provider.

Please select one of the following options.
If no selection is made below, our office will place a courtesy reminder telephone call 24 hours prior to your scheduled appointment.

☐ I prefer to be contacted by phone at the following phone number regarding appointment reminders:
Phone Number: _____

☐ I prefer to be contacted by email at the following address regarding appointment reminders:
Email Address: _____

☐ I prefer to be contacted by SMS/text message regarding appointment reminders:
_____ _____
Phone Number or Device ID Carrier Name

I understand that by signing this document I am giving permission to send only appointment date and time reminder information by the method chosen above. No other protected information will be sent. I am aware that text messages and email are not protected or secure methods of transmitting information. Others may be able to view the information and NNCS, once sent, cannot protect this information of scheduled appointments. I understand the potential risks and will hold harmless NNCS in the event others obtain access to the information of scheduled appointment dates and times. I have read the above, understand and agree to accept electronic reminders of appointment dates and times.

Client/Guardian name: _____

Signature: _____ Date: _____

Would You Like To Register To Vote Here Today?

(Please Check One)

☐ I do not need an application to register to vote, I am already registered to vote at my current address, or I am not eligible to register to vote.

☐ Yes. I would like to register to vote.

☐ No. I do not wish to register to vote at this time.

Note: If you do not check any box you will be considered to have decided you do not wish to register to vote at this time.

Signature: _____ Date: _____

This form will be retained with this agency.

To register to vote in California, you:

1. Must be a **citizen** of the United States.
2. Must live in the State of California.
3. Must be at least 18 years old by the date of the next election.
4. You may not be currently in prison or on parole for the conviction of a felony, or be judged by a court to be mentally incompetent.

WARNING: Under state and federal law, it is a crime to submit a voter registration affidavit if you know you are not eligible to vote.

Important Notices:

1. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.
2. If you move to a new address, if you change your name, or if you change your political party you must fill out a new voter registration form.
3. You may fill out the voter registration form in private, or if you would like help filing out the voter registration form we will help you. However the decision whether to seek or accept help is yours. **If you would like help, please ask.**
4. If you believe that someone has interfered with your right to register or to decline to register, or your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with the Secretary of State by calling toll-free 800-345-VOTE or by writing to Secretary of State, 1500 11th Street, Sacramento, CA. 95814.

For Agency Use Only

Voter Registration Form Completed: Yes__ No__ Employee Initials: _____

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Notice Of Privacy Practices

- 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.

- WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).
  We are legally required to protect the privacy of your PHI, which includes information that can be used to identify you that we have created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. We must provide you with this notice about our privacy practices, and this notice must explain how, when, and why we will "use" and "disclose" your PHI. A "use" of PHI occurs when we share, examine, utilize, apply, or analyze it within our practice. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure was made. And, we are legally required to follow the privacy practices described in this Notice.
- However, we reserve the right to change the terms of this Notice, and our privacy policies at any time. Any changes will apply to all PHI already on file. Before we make any important changes to the privacy policies, we will promptly change this notice and post a new copy in our office and on our website. You can also request a new copy of this notice in our office at any time.

- HOW MAY WE USE AND DISCLOSE YOUR PHI.
  We will use and disclose your PHI for many different reasons. For some of these uses or disclosures, we will need your prior authorization, for others however, we do not. Listed below are the different categories of our uses and disclosures along with some examples of each category.
  - USES AND DISCLOSURES RELATING TO TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS DO NOT REQUIRE YOUR PRIOR WRITTEN CONSENT. We can use and disclose your PHI without your consent for the following reasons:
    - FOR TREATMENT. We can use and disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your case. We can disclose your PHI to your physician in order to coordinate your care.
    - TO OBTAIN PAYMENT FOR TREATMENT. We can use and disclose your PHI to bill and collect payment for the treatment and services provided to you. For example, we might send your PHI to your insurance company or health plan to get paid for the health care we have provided to you. We may also provide your PHI to our business associates, such as billing companies, claim processing companies, and others that process our health care claims.
    - FOR HEALTH CARE OPERATIONS. We can use or disclose your PHI to operate our practice. For example, we might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others to make sure we are complying with applicable laws.
    - OTHER DISCLOSURES. We may also use or disclose your PHI to others without your consent in certain situations. For example your consent is not required if you need emergency treatment, as long as we try to get your consent after treatment is rendered, or if we try to get your consent but you are unable to communicate with us (such as if you are unconscious or in acute pain) and we believe you would consent to such treatment if you were able to do so.
  - CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR CONSENT. We can use and disclose your PHI without your consent or authorization for the following reasons:
    - WHEN DISCLOSURE IS REQUIRED BY FEDERAL, STATE, OR LOCAL LAW; JUDICIAL OR ADMINISTRATIVE PROCEEDINGS; OR LAW ENFORCEMENT. For example, we may make a disclosure to applicable officials when a law requires us to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
    - FOR PUBLIC HEALTH ACTIVITIES. For example, we may have to report information about you to the county coroner.
    - FOR HEALTH OVERSIGHT ACTIVITIES. For example, we may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
    - FOR RESEARCH PURPOSES. In certain circumstances, we may provide PHI in order to conduct medical research.
    - TO AVOID HARM. In order to avoid a serious threat to the health or safety of a person or the public. We may need to provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
    - FOR SPECIFIC GOVERNMENT FUNCTIONS. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
    - FOR WORKERS COMPENSATION PURPOSES. We may disclose PHI in order to comply with workers' compensation laws.
    - APPOINTMENT REMINDERS AND HEALTH RELATED BENEFITS AND SERVICES. We may use PHI to provide appointment reminders or give you information about treatment alternatives or other health care services or benefits we offer.
  - CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.
    - DISCLOSURES TO FAMILY, FRIENDS, OR OTHERS. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your case or the payment for your health care, unless you object in whole or in part. The Opportunity to consent may be obtained retroactively in emergency situations.

Notice Of Privacy Practices (Cont'd)

- OTHER USES AND DISCLOSURES REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION.
  In any other situation not previously described in this section we will ask for your written authorization before using or disclosing your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that we haven't already taken any action in reliance on such authorization).

- WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.
  You have the following rights with respect to your PHI.
  - THE RIGHT TO REQUEST LIMITS ON USES AND DISCLOSURES OF PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request, but we are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.
  - THE RIGHT TO CHOOSE HOW WE SEND PHI TO YOU. You have the right to ask that we send information to you at an alternative address (such as sending information to your work address rather than your home address) or by alternate means (such as email rather than regular mail). We must agree to your request so long as we can easily provide the PHI to you in the format and method you have requested.
  - THE RIGHT TO SEE AND GET COPIES OF YOUR PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we do not have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.
  - If you request copies of your PHI, we will charge you not more that $25.00 for electron transmission of records. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.
  - THE RIGHT TO GET A LIST OF THE DISCLOSURES WE HAVE MADE. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list will also not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures prior to April 15th, 2003.
  - We will respond to your request for a list of disclosures within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide this list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable cost-based fee for each additional request.
  - THE RIGHT TO CORRECT OR UPDATE YOUR PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and the reason for the request in writing. We will respond within 60 days of receiving your request to correct or update your PHI. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done so, and tell others that need to know about the change to your PHI.
  - THE RIGHT TO GET THIS NOTICE BY EMAIL. You have the right to get a copy of this notice by email. Even if you have agreed to receive this notice via email, you also have the right to request a paper copy of it.

- HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.
  If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington D.C. 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

- PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.
  If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact our Office Manager at 951-694-0695.

Ben Novell, MS, LMFT, LPCC
Marriage and Family Therapist
State License MFC25733

Janelle K. Novell, MA, LMFT, RPT-S
Marriage and Family Therapist
State License MFC32101

Acknowledgement Of Receipt Of Notice Of Privacy Practices

Patient or Subscriber Name:_____
(Please print patient or subscriber name)

I, _____,
(Print name of patient, subscriber, conservator, parent or legal guardian signing below)
acknowledge receipt of the Notice of Privacy Practices, which explains limits on ways in which Novell & Novell Counseling Services may use or disclose personal health information (PHI) to provide service.

Signature:_____ Date:_____

If not signed by patient, indicate relationship: _____
NOTE: Parent must have legal custody. Legal guardians and conservators must show proof.

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THIS SECTION TO BE FILLED OUT BY NOVELL & NOVELL COUNSELING SERVICES STAFF

Patient did receive the Notice of Privacy Practices, but did not sign this Acknowledgement of Receipt because:
☐ Patient left office before Acknowledgement could be signed.
☐ Patient did not wish to sign this form.
☐ Patient cannot sign this form because: _____

Patient did not receive the Notice of Privacy Practices because:
☐ Patient required emergency treatment.
☐ Patient declined the Notice and signing this Acknowledgement.
☐ Other:_____

Name:_____
(Print name of provider or provider's representative)

Signature:_____ Date:_____
(Signature of provider or provider's representative)