Joel D. Carnazzo, Psy.D.

Licensed Clinical Psychologist
550 Fox Glen Ct.
Barrington, IL 60010
847-381-5001 (o)
847-381-5059 (f)

Welcome

What can I expect from my initial visit?

You will meet with me to discuss what concern(s) brings you to therapy. This meeting should help clarify and identify your treatment options. Our initial assessment may take 1 to 3 sessions. During this time, I may ask your permission to contact previous providers to obtain past treatment information. This will give us the necessary information to completely understand your concerns and my ability to assist you. This is also an essential time period for you to ensure that I am a good fit for your personal needs. Establishing a professional, therapeutic relationship with me is a mutual decision based on these factors. If you choose not to receive services, I will provide you with the names of other qualified professionals that may better assist you.

What can I expect from therapy?

The therapeutic process assists in resolving personal difficulties and acquiring skills, attitudes, and knowledge to live a positive and productive life. This occurs through regular contact with me where we discuss the important issues in your life and address your treatment goals.

What are your credentials and clinical background?

I have a doctoral degree in clinical psychology from the Adler School of Professional Psychology, accredited by the American Psychological Association (APA). I am a licensed psychologist in Illinois, and a member of the APA and the National Register of Health Service Providers in Psychology. I specialize in working with adults and adolescents to help them address relationship issues, anxiety, depression, eating concerns, and performance-based issues among many others.

How much do services cost?

My fee is $155 per therapy session & $175 for initial intake assessment. Payment is usually expected at the end of each session in the form or cash, check, or credit card.

How do I utilize my insurance benefits to cover services?

Your health insurance plan may help you pay for therapy. If your health insurance will pay part of my fee, I will complete the insurance claims forms. If you need a monthly statement for insurance or tax purposes, I will provide that upon request. However, you are ultimately responsible for payment of services rendered.

What if I need to cancel or reschedule a session?

Any cancellations of appointments must be made at least 24 hours in advance of the scheduled session. If you do not call to cancel and/or fail to show, you will be charged $155 for that appointment. If you need to reschedule an appointment, please contact me as early as possible and I will make every effort to schedule another time to meet.

What if I need to contact you before my scheduled appointment?

You may leave a message on my confidential voicemail. I make every effort to return phone calls within 24 hours. If you are in an emergency situation, call 911 or proceed to your nearest emergency room for immediate care.

Are my visits confidential?

The information you share in therapy is confidential and will not be disclosed without your written permission. There are some exceptions to confidentiality including: (1) If you are at imminent risk to harm yourself or another person, the law requires me to try to protect you and/or the other person by informing appropriate individuals to maintain safety; (2) If you disclose information pertaining to child or elder abuse, the law requires me to report this to authorities; and (3) If I receive a court-order for your clinical record or to testify. If such rare situation(s) occurs, I will make every effort to fully discuss it with you before taking action.

I certify by my signature below that I have read, fully understand, and agree to abide by the terms of the Outpatient Services Contract.

______________________________	________	______________________________	________
Signature of Client	Date	Joel D. Carnazzo, Psy.D.	Date

Joel D. Carnazzo, Psy.D.

550 Fox Glen CT
Barrington, IL 60010
847-381-5001 (o)
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Financial Contract

This contract outlines my financial and business policies. My fee is $175 for initial intake assessment and $155 for therapy sessions. Payment is usually expected at the end of each session in the form of cash, check, or credit card. My professional services are covered by Blue Cross/Blue Shield PPO, Cigna, ComPsych, and Medicare. BCBS PPO, Cigna, ComPsych or Medicare participants will be billed for co-payments and deductibles after receiving a benefits summary. Any designated co-payments and/or deductibles are your financial responsibility.

If you have other insurance, it may cover services for out-of-network providers. It is your responsibility to contact your insurance company to access information regarding your mental health benefits. If your health insurance will pay part of my fee, I will complete a monthly statement that you can submit to your insurance for reimbursement. However, you are ultimately responsible for payment at the time services are rendered.

If you think you may have trouble paying your bill on time, please discuss this with me so we can arrive at a solution. If your account has not been paid for more than 60 days and arrangements have not been made, a collection agency may be utilized to secure payment.

Payment Method: ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance

Insurance Information (Please complete or provide copy of your insurance card):

Insurance Company: ______________________________

Subscriber Name: ______________________________ Subscriber DOB: ______________

Identification/Policy #: ______________________________

Group or Enrollment #: ______________________________

Insurance. Co. Phone: ______________________________

PLEASE INITIAL:

_____ *Financial Relationship*
I agree that a financial relationship with this therapist will continue as long as the therapist provides services to me. I agree to pay for services provided through the termination of services.

_____ *Accepting financial responsibility*
I understand that I am ultimately responsible for the services provided by this therapist to me, although other persons or insurance companies may make payments on my account.

_____ *Authorization for release of information for billing purposes*
I hereby authorize the release of any information necessary for third-party submission and/or payment for services. I authorize payment of third-party benefits to Joel D Carnazzo, Psy.D. for mental health services described herein.

_____ *Cancellation Policy*
Any cancellations of appointments must be made at least 24 hours in advance of the scheduled session. If I do not call to cancel and/or fail to show, I will be charged $155 for that appointment.

______________________________ ________ ______________________________ ________

Signature of Client Date Joel D. Carnazzo, Psy.D. Date
(or person assuming financial responsibility) Licensed Clinical Psychologist

Joel D. Carnazzo, Psy.D.

550 Fox Glen Ct
Barrington, IL 60010
847-381-5001 (o)
847-381-5059 (f)

Credit Card Authorization Form

Card Holder Information		
Card Holder Name:		
Address:		
City:	State:	Zip:
Telephone:	Alt. Telephone:	
Billing Address (if different from above):		
City:	State:	Zip:

Payment Authorization

Card Type: ☐Visa ☐Mastercard ☐Discover ☐American Express

Card Number:_________________-- _________________--_________________--__________________

Exp. Date:_____________________

Card Identification Number:________________________
(This is the 3 digits on the back of your card)

I wish to authorize ongoing payments for sessions or late cancellations from Joel D. Carnazzo, Psy.D., using this credit card authorization form. I further authorize from Joel D. Carnazzo, Psy.D., to maintain my card information on file. I agree that I will pay for these sessions or late cancellations and indemnify and hold from Joel D. Carnazzo, Psy.D., harmless against any liability pursuant to this authorization. I understand that my signature on this form will serve as authorized signature on the credit card charge slip. This authorization will remain in effect until such time when a written request to cease charges is received.

Joel D. Carnazzo, Psy.D., will process all charges using a secure credit card service. Charges will be processed to the above stated account 1 to 5 business days after the session date or late cancellation.

CONFIDENTIAL

_______________________________	_______________________________	_________________
Printed Name	Signature	Date

Joel D. Carnazzo, Psy.D.

550 Fox Glen CT
Barrington, IL 60010
847-381-5001 (o)
847-381-5059 (f)

Identifying Information

Name: ______________________________ Birthdate: ____________ Age: ________

Address: ____ ____________
(Street) (Apt/Unit#)

______________________________ __________ ____________
(City) (State) (Zip)

Marital Status: ☐ Single ☐ Married ☐ Separated / Divorced ☐ Widowed ☐ Committed Relationship

Ethnic/Racial Identity: ______________________________

To (re)schedule appointments, where may I contact you?

☐ Cell #: ______________________________ Voicemail OK? ☐ Yes ☐ No

☐ Home #: ______________________________ Voicemail OK? ☐ Yes ☐ No

☐ Email: ____

Who may I contact in case of an emergency?

Name: ______________________________ Phone: ____________________

Relationship to you: ______________________________

Referral Source (How did you learn about my practice):

☐ Referred by ______________________________

☐ Insurance Provider ☐ Psychology Today ☐ Network Therapy ☐ Google ☐ Other ____________

Primary Care Provider

Name: ______________________________ Phone: ____________

Clinical Information

Briefly describe your reasons for seeking services

____

____

Do you have specific goals for therapy?

____

____

Have you ever had previous counseling or psychotherapy? ☐ Yes ☐ No

Name: ______________________________ *Approx. Mo/Year:* ____________

Name: ______________________________ *Approx. Mo/Year:* ____________

Have you ever been hospitalized for a psychiatric reason? ☐ Yes ☐ No
Have you ever made a suicide attempt/gesture? ☐ Yes ☐ No

Please list current medical conditions: ____

____

____

Please list current medications (prescribed & OTC):

Medication Name	Dose

Please indicate use of any alcohol and/or drugs

		Current Pattern of Use					
	Age of First Use	Daily	Weekly	In last 30 days	In Past Year	In Your Lifetime	Never
Alcohol							
Nicotine							
Marijuana							
Ecstasy or other Hallucinogens							
Cocaine and/or other stimulants							
Opioids (heroin, morphine)							
Sedatives, hypnotics, tranquilizers							

Family History:. Please use the suggested symbols to indicate if a relative has been diagnosed, treated or suspected of having with one of these health conditions. ***Dx*** *= Diagnosed.* ***Tx*** *= Received Treatment.* ***Sus*** *= You suspect they suffer from this condition.*

	Mother	*Father*	*Sibling*	*Children*	*Father's Parent*	*Mother's Parent*
Depression						
Anxiety						
Panic Attacks						
OCD						
Alcoholism						
Drug Addiction						
Suicide Attempt						
Bipolar Disorder						
ADHD						
Learning Problems						
Schizophrenia						
Thyroid Problems						
Sleep Disorder						
Other:						
Other:						

Thank you for completing the paperwork. Data is solely used for the purpose of understanding treatment concerns and will be held strictly confidential.

PATIENT HEALTH QUESTIONNAIRE (PHQ-SADS)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability

A. During the last 4 weeks, how much have you been bothered by any of the following problems?	**Not bothered (0)**	**Bothered a little (1)**	**Bothered a lot (2)**
1. Stomach pain..	☐	☐	☐
2. Back pain..	☐	☐	☐
3. Pain in your arms, legs, or joints (knees, hips, etc.)...	☐	☐	☐
4. Feeling tired or having little energy..........................	☐	☐	☐
5. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐
6. Menstrual cramps or other problems with your periods......WOMEN...ONLY............................	☐	☐	☐
7. Pain or problems during sexual intercourse............	☐	☐	☐
8. Headaches..	☐	☐	☐
9. Chest pain..	☐	☐	☐
10. Dizziness..	☐	☐	☐
11. Fainting spells..	☐	☐	☐
12. Feeling your heart pound or race............................	☐	☐	☐
13. Shortness of breath..	☐	☐	☐
14. Constipation, loose bowels, or diarrhea.................	☐	☐	☐
15. Nausea, gas, or indigestion....................................	☐	☐	☐

PHQ-15 Score ☐ = _____ + _____

B. Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all (0)**	**Several days (1)**	**More than half the days (2)**	**Nearly every day (3)**
1. Feeling nervous anxiety or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying..................	☐	☐	☐	☐
3. Worrying too much about different things..................	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still....................	☐	☐	☐	☐
6. Becoming easily annoyed or irritable...........................	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen	☐	☐	☐	☐

GAD-7 Score ☐ = _____ + _____ + _____

C. Questions about anxiety attacks.

	NO	YES
a. In the <u>last 4 weeks</u>, have you had an anxiety attack — suddenly feeling fear or panic?……………………………….. **If you checked "NO", go to question D.**	☐	☐
b. Has this ever happened before?………………………	☐	☐
c. Do some of these attacks come <u>suddenly out of the blue</u> — that is, in situations where you don't expect to be nervous or uncomfortable?…………………………………………………	☐	☐
d. Do these attacks bother you a lot or are you worried about having another attack?…………………………………….….	☐	☐
e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, or your heart racing, pounding or skipping?…………………………………..………..	☐	☐

D. Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?	**Not at all (0)**	**Several days (1)**	**More than half the days (2)**	**Nearly every day (3)**
1. Little interest or pleasure in doing things.......……………	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless.…………………..….	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much.…………………………………………… ………….	☐	☐	☐	☐
4. Feeling tired or having little energy.........…………...…..	☐	☐	☐	☐
5. Poor appetite or overeating....................……………….	☐	☐	☐	☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.…………………..	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television.……………………….	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.…………………………………………………..	☐	☐	☐	☐
9. Thoughts that you would be beter off dead of or hurting yourself in some way.……………………………………..	☐	☐	☐	☐

PHQ-9 Score ☐ = _____ + _____ + _____

E. If you checked off <u>any</u> problems on this questionnaire, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Complete this form if you would like me to coordinate care with other treatment providers, or release information to third parties for other purposes. Please let me know about any questions.

*Name of Patient:*___________________________________ *Date of Birth:*__________________

I authorize the use or disclosure of the above named individual's health information, its employees and agents, to furnish:

FROM:		**TO:**	
Name:	JOEL D. CARNAZZO, PSYD	Name	
Address:	550 FOX GLEN CT	Address:	
	BARRINGTON, IL 60010		
Telephone:	(847) 381-5001	Telephone:	
Fax:	(847) 381-5059	Fax:	

The type of information to be used or disclosed is as follows *(check all that apply)*:

- ☐ Record for Dates of Service
- ☐ Entire Mental Health Record
- ☐ Billing Statements
- ☐ Discharge Summary
- ☐ Therapy Notes
- ☐ Consultations
- ☐ Other *(please specify)*_____________________________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services even though I am protected by Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patients Records, 42 CFR Part 2, the Illinois AIDS Confidentiality Act, or the Mental Health and Developmental Disabilities Confidentiality Act. A request in writing must be made to exclude the above from the disclosed information.

The purpose for which this disclosure is being made is (check all that apply):

- ☐ Sharing with other healthcare providers
- ☐ My personal records
- ☐ Other *(please describe)* ____

I understand that I have the right to revoke this Authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. In accordance with the Mental Health Code – No person or agency to whom any information is disclosed may redisclose such information unless the person who consented to the disclosure specifically consents to such redisclosure. I understand that I have the right to inspect and copy the information that is to be disclosed.

This Authorization expires on: ______ / ______ / ______. If I fail to specify an expiration date, this authorization will expire six months from date of signature.

I understand authorizing the use or disclosure of the information identified above is voluntary. Healthcare treatment, payment, enrollment in the health plan, or eligibility for benefits is not conditioned on signing the authorization. Beyond this, my refusal to consent may have the following consequence – failure to disclose information.

____________________________________ ________ ____ _______
Witness *Date* *Signature of Patient or Legal Representative* *Date*

This Authorization must be signed by the patient or guardian if patient is less than 12. In keeping with the Mental Health & Services Disability Confidentiality Act, if the patient is a minor and recipient is 12 years of age or older, then this authorization must be signed by the patient. If the patient is mentally incompetent and over the age of 18, this Authorization must be signed by the appointed legal representative of the patient.

Written Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices. The Notice describes my rights to privacy and how my Protected Health Information may be used or disclosed. I understand that I should read it carefully. I am aware that may obtain an additional copy of the Notice by calling 847-381-5001 or by requesting one at Dr. Carnazzo's office.

____
Printed Name

____ ___________________
Signature Date

As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

____
Printed Name

____ ___________________
Signature Date

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

I am required by applicable federal and state laws to maintain the privacy of your Protected Health Information (PHI). I am also required to give you this notice about our privacy practices, my legal duties, and your rights concerning your PHI. I must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **September 23, 2013**, and will remain in effect until I replace it. I reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted applicable law. I reserve the right to make the changes in my privacy practices and the new terms of our notice effective for all PHI that I maintain, including medical information I created or received before I made the changes. You may request a copy of our notice (or any subsequent revised notice) at any time.

Uses and Disclosures of Protected Health Information Without Your Authorization

In certain situations, which are described in the **Uses and Disclosures Based on Your Written Authorization** Section below, I must obtain your written authorization in order to use and/or disclose your PHI. However, unless the PHI is considered Highly Confidential Information and the applicable law regulating such information imposes special restrictions on me, I may use and disclose your PHI without your written authorization for the following purposes

Treatment: I will use and disclose your PHI to provide, coordinate or manage your health care and any related services. This includes the coordination or management of our health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, I may disclose your PHI from time to time to anther physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services I recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. Patients have the right to restrict certain disclosures of PHI to health plans/insurance companies if the patient pays out-of-pocket in full for the health care service.

Health Care Operations: I may use or disclose, as needed your PHI in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, licensing, and conducting or arranging for other business activities. For example, I may call you by name in the waiting room. I may use or disclose your PHI, as necessary, to contact you by telephone or email to remind you of your appointment.

Business Associates: I will share your PHI with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between my office and a business associate involves the use or disclosure of your PHI, I will have an agreement that contains terms that will protect the privacy of your PHI.

Research; Death; Organ Donation: I may use or disclose your PHI for research purposes in limited circumstances. I may disclose the PHI of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: I may disclose your PHI to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. I may disclose your PHI to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: I may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, I may disclose your PHI if I believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: I may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, I may disclose your PHI, if I believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. I may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: I may use or disclose your PHI when I am required to do so by the law. For example, I must disclose your PHI to the U.S. Department of Health and Human Services upon request for purposes of determining whether I am in compliance with federal privacy laws. I may disclose your PHI when authorized by workers' compensation or similar laws. Illinois Public Act 98-63 98-63 mandates physicians, licensed psychologists, and qualified examiners to report certain mental health data to the Illinois Department of Health Services FOID Mental Health Reporting System. This includes when a determination is made that a client has a developmental disability.

Process and proceedings: I may disclose your PHI in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, I may disclose your PHI to law enforcement officials.

Law Enforcement: I may disclose limited information to a law enforcement official concerning the PHI of a suspect, fugitive, material witness, crime victim or missing person. I may disclose the PHI of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. I may disclose PHI where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

More Stringent State and Federal Laws: Federal law under HIPAA preempts state laws that are in conflict with Privacy Rule requirements or those that provide *less stringent* privacy protections. Those states that have *more stringent* privacy laws would preempt Federal law. The State law of Illinois is more stringent than HIPAA in several areas. Certain federal laws also are more stringent than HIPAA. I will continue to abide by these more stringent state and federal laws. **More Stringent Federal Laws:** The federal laws include applicable internet privacy laws, such as the Children's Online Privacy Protection Act and the federal laws and regulations governing

the confidentiality of health information regarding substance abuse treatment. **More Stringent State Laws:** State law is more stringent when the individual is entitled to greater access to records than under HIPAA. State law also is more restrictive when the records are more protected from disclosure by state law than under HIPAA. More stringent state law protections in Illinois include: (1) Sensitive information: Illinois law, with some exceptions, may require that we obtain your written permission, or in some instances, a court order to disclose sensitive information. Sensitive medical information includes that which may deal with genetic testing, HIV/AIDS, mental health, alcohol and substance abuse, and sexual assault. (2) Minors: Minors in Illinois have more rights to confidentiality and protection of certain information related to reproductive health, behavioral health and substance abuse under HIPAA. (3) Professional Licensure: Illinois law may require your written permission if certain medical information is to be used in various review and disciplinary proceedings of healthcare professionals by state authorities.

Uses and Disclosures Based on Your Written Authorization

Other uses and disclosures of your PHI will be made only with your authorization, unless otherwise permitted or required by law as described below. You may give me written authorization to use your PHI or to disclose it to anyone for any purpose. If you give me an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, I will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, I may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, I may disclose such information as necessary if I determine that it is in your best interest based on my professional judgment. I may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: I will not accept any payments from other organizations or individuals in exchange for making communications to you about treatments, therapies, health care providers or services unless you have given us your authorization to do so or the communication is permitted by law. In addition, we may give you promotional gifts of nominal value without obtaining your written authorization.

Sale of Protected Health Information: We will not make any disclosure of PHI that is a sale of PHI.

Psychotherapy Notes: We will not use or disclose psychotherapy notes about you without your authorization except for use by the mental health professional who created the notes to provide treatment to you or to defend myself in a legal action or other proceeding brought by you.

Uses and Disclosures of Your Highly Confidential Information:. Federal and state law requires special privacy protections for certain health information about you (Highly Confidential Information), including AIDS/HIV records, Alcohol and Drug Abuse Treatment Program records and other health information that is given special privacy protection under state or federal laws other than HIPAA.

Patient Rights

Access: You have the right to look at or get copies of your PHI, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your PHI. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, I will charge you $0.50 per page, $18 per hour for staff time to locate and copy your PHI, and postage if you want the copies mailed to you. If you prefer, I will prepare a summary or an explanation of your PHI for a fee. Contact me using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which I or my business associates disclosed your PHI for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided for the past six (6) years. I will provide you with the date on which I made the disclosure, the name of the person or entity to which I disclosed your PHI, a description of the PHI I disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, I may charge you a reasonable, cost-based fee for responding to these additional requests. Contact me using the information listed at the end of this notice for a full explanation of our fee structure.

Breach Notification: (1) When I become aware of or suspect a breach of your PHI, I will conduct a risk assessment. I will keep a written record of that risk assessment. (2) Unless I determine that there is a low probability that PHI has been compromised, I will give notice of the breach to all affected parties. (3) The risk assessment can be done by a business associate if it was involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in its control, I will provide any required notice to patients and HHS. (4) After any breach, particularly one that requires notice, I will re-assess its privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches.

Restriction Requests: You have the right to request that I place additional restrictions on my use or disclosure of your PHI. I am not required to agree to these additional restrictions, but if I do, I will abide by our agreement (except in an emergency). Any agreement I may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. I will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that I communicate with you in confidence about your PHI by alternative means or to an alternative location. You must make your request in writing. I must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you. Other uses and disclosures not described in the Privacy Notices will be made only with authorization from the individual.

Amendment: You have the right to request that I amend your PHI. Your request must be in writing, and it must explain why the information you want amended or for certain other reasons. If I deny your request, I will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you want amended. If I accept your request to amend the information, I will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of the information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about my privacy practices or have questions or concerns, please contact me using the information below. If you believe that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI or in response to a request you made, you may complain to me using the contact information below. You may also submit a written complaint to the U.S. Department of Health and Human Services. I will provide you with the address to file your compliant with the U.S. Department of Health and Human Services upon request. I will not retaliate in any way if you choose to file a complaint.

Name of Contact Person: Joel D. Carnazzo, Psy.D. E-mail: jcarnazzo@DrCarnazzo.com
Telephone: (847) 381-5001
Address: 550 Fox Glen CT, Barrington, IL. 60010