BEHAVIORAL HEALTH ASSOCIATES
1000 E. Lexington Ave. Ste. 30
Danville, KY. 40422
Ph. (859) 209-2198 Fax: (859) 209-4439

Hello and Welcome!

First, we want to thank you for choosing Insight Behavioral Health Associates in seeking help for your behavioral and mental health needs. We know that seeking help can be difficult – but *that*, is why we are here.

We, at Insight Behavioral Health Associates, have a common goal among our providers and staff – to assist our patients in moving toward the most healthy and adaptive responses that promote long term successes. Whether you choose to participate in therapy, medication management, or medication management with therapy – our mission is to empower our clients with the Insight needed to make good decisions about their behavioral health needs.

Our experience in providing behavioral health services also recognizes how easy it is to be overwhelmed when becoming a new patient – If you have any questions in completing the following documents, please do not hesitate to contact us. Call (859) 209-2198 or visit us at our virtual waiting room from our website at www.InsightBHA.com. We can help you through the process.

Getting Started:
The following documents enclosed in this packet are essential to starting this journey. Please take time to review the notices, but also be thoughtful in completing the mental and physical health questionnaire. Please answer the mental health questions to your comfort level while being accurate about the medication and health questions. This allows us to save you time and money by getting to what's most important – discussing your concerns and reviewing the best treatment options.

The Documents:
Complete and Return:

- *Intake Registration Form* – basic information about you.
- *Medical and Mental Health History* – a mental and medical health questionnaire

Keep for your records:

- *HIPAA Notice of Privacy Practices* – our HIPAA and privacy practices notice regarding your protected health information.
- *No Surprises Act Notice* – Required notice of no surprise billing laws enacted in January 2022.

Once we receive your completed packet, we will review it to prepare for your first appointment. Please arrive 30 minutes early (even for telehealth) to complete any additional documents and pay for any copayments, deductibles, or fees for services.

What to expect:

For Telehealth:
We've made our virtual services to be like going to a regular office as much as possible. Simply go to www.InsightBHA.com to enter our online "waiting room". Our staff will greet you and guide you through the rest of your virtual appointment.

For Office Visits and Telehealth:
Be prepared to spend one to two hours for your first appointment. On the day of your appointment, bring with you or have available:

- Your driver's license.
- Your insurance card(s)
- All bottles of medications you are currently taking
- Source of payment for services, copays, or unpaid deductibles.
  (Cash and check accepted in office. Visa, MasterCard, HSA cards, are accepted online or in office)

Follow up appointments are decided by you and your clinician during the first appointment.

Once more, if you have any questions or need assistance in completing your documents, don’t hesitate to contact us or visit our website.

Thank you again for choosing Insight Behavioral Health Associates. We look forward to meeting you.

William “Scott” Gibson

William “Scott” Gibson, APRN, PMHNP-BC / Clinician & Owner

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Intake Registration Form

CONFIDENTIAL INFORMATION

Preferred Identification: ☐ Mr./his/him/he ☐ Mrs. / ☐ Ms.- hers/her/she ☐ They/them/their ☐ Other: _______

First name: _________________________ Middle: ___________________________Last: _____________________________

Maiden name: _____________________ Date of Birth: ____________________ Birth Sex: ☐ Male ☐ Female ☐ Intersex

Preferred Name: __________________________________

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other: _________

Marital Status: ☐ Single ☐ In a relationship ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
☐ Cohabitating with Significant other.

Employment status: ☐Unemployed ☐ Employed

Patient Address: __________________________________ City: ____________________ State: _____ Zip: __________

Mailing address if different: ____

Mobile: (_____) ________________ Home phone: (_____) __________________ Work: (_____) _______________

Email Address: ____

SS#: _______ -_____ - __________

Emergency Contact: ____ Phone: (____) ______________

Is it okay to discuss information with your Emergency Contact for treatment purposes? ☐Yes ☐No

Primary Care Physician (PCP): ________________________________ City: _______________ Phone: (____) _______________

Is it okay to discuss information to your PCP? ☐Yes ☐No

Is sending appointment reminders to your email or mobile (text) okay? ☐Yes ☐No

Preferred means of contact: ☐ Voice ☐ Text ☐ Email

Insight Behavioral Health Associates uses a patient portal (website) for you to access messages, labs, appointments, billing / payments, and other information. Do you wish to have access to this service (you must choose Yes if you choose to receive Telehealth Services)?

☐Yes ☐No

Does any person have guardianship or Power of Attorney over you that may affect the implementation of your mental health needs?

☐Yes ☐No

Do you have a living will or mental health directive in the event of an emergency?

☐Yes ☐No

If you answered "Yes" to either of the two above questions please submit copies of these documents.

How did you hear about us: ☐ Friend ☐ Family ☐ Online website ☐ Google ☐ My medical provider.
☐ Other? ________________

Payment / Insurance Information

Responsible Party: ____________________________________ Relationship to Patient: ____________________

Phone: (____) ________________ Email: ____

Address if Different than Above: ____

Primary Insurance Company:
Name of Insurance Carrier (Aetna, Humana, BlueCross/BlueShield, etc.): ____________________

Name of Insured (person carrying/paying for insurance): _____________________________________

Member #: ________________________

Policy #: __________________________

Secondary Insurance Company:
Name of Insurance Carrier (Aetna, Humana, BlueCross/BlueShield, etc.): ____________________

Name of Insured (person carrying/paying for insurance): _____________________________________

Member #: ________________________

Policy #: ___________________________

I hereby authorize Insight Behavioral Health Associates (IBHA) to release relevant and pertinent information from my medical records (further defined in the privacy notice) and allow photocopies of my signed forms to be used for the purposes of treatment and payment of services. IBHA may not use my information for any other purposes unless I have signed authorization to allow IBHA to do so. I also agree to allow IBHA to file insurance claims on my behalf. I also authorize and direct my insurance company to issue payment for benefits directly to Insight Behavioral Health Associates. Regardless of my insurance benefits I understand that I am financially responsible for fees - such as copays, deductibles and fees for services rendered - not paid as a benefit of my insurance carrier.

If the patient is under the age of 18, I attest that I have legal custody of this child and am therefore allowed to initiate,and consent to, treatment; and are responsible for any debt for services incurred.

Signature of Patient (Parent/Guardian):____Date:_______________

Printed Name: ____

Relationship to patient (if not signed by the patient):

____

Please Remember to provide a front and back copy of your Driver's License / ID and Insurance card(s).

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Medical and Mental Health History

Preferred Identification: □ Mr./his/him/he □ Mrs. / □ Ms.- hers/her/she □ They/them/their □ Other: _______

First name: _________________________ Middle: ___________________________Last: _____________________________

Maiden name: _____________________ Date of Birth: ____________________ Birth Sex: □ Male □ Female □ Intersex

Preferred Name: __________________________________

Mental Health History:

Are you concerned about the following? If yes, briefly explain how long has the problem been going on.

Depression/Mood Elevation Symptoms: □ No □ Yes____

Anxiety Symptoms: □ No □ Yes ____

Issues after Trauma: □ No □ Yes ____

Eating Disorder symptoms: □ No □ Yes ____

Psychotic Symptoms: (hallucinations): □ No □ Yes ____

ADHD Inattention / Hyperactivity Symptoms: □ No □ Yes: ____

What symptoms or situations brought you to seek help?

____

____

Check all that apply to you:

Mood	**Sleep**	**Appetite / Weight**
□ Sadness	□ Problems falling asleep	□ Increased appetite
□ Tearfulness	□ Problems staying asleep	□ Decreased appetite
□ Feeling Empty	□ Waking in early morning	□ Increased Weight
□ Suicidal thoughts / Attempts	□ Nightmares	□ Decreased Weight
□ Anxious	□ Waking in a panic	□ Restrictive Dieting
□ Guilty	□ Sleeping too much	□ Over-exercising
□ Social Anxiety	□ Sleeping too little	□ Binge-Eating
□ Elevated Mood		□ Purging
□ Mood Swings	**Energy**	□ Taking laxatives
□ Self-Harming (cutting)	□ Too Much	
	□ Too Little	**Concentration / Focus**
Impulsivity		□ Cannot start/stick with/complete tasks
□ Impulsive Spending	**MOTIVATION/INTEREST**	□ Racing mind / thoughts
□ Putting self in danger	□ Little/no joy in pleasurable things	□ Procrastinating
□ Interrupting others	□ No drive to accomplish tasks	□ Difficulties concentrating on:
□ Difficulty waiting your turn		□ School / homework
		□ Reading
		□ Conversations

Have you had any recent major stressors in your family (deaths, moves, marital changes relationship problems, financial, legal, etc.)?

____

____

Have you received mental health treatment from a psychiatrist or a psychiatric nurse practitioner who has prescribed medications to you in the past?

☐ No ☐ Yes:

Provider Name / Facility	Start Date	End Date
Provider Name / Facility	Start Date	End Date

Have you received, or are you receiving, mental health treatment from a therapist or counselor?

☐ No ☐ Yes:

Therapist / counselor name / Facility	Start Date	End Date
Therapist / counselor name / Facility	Start Date	End Date

Have you ever had psychiatric testing by a psychologist (for i.e., IQ, brain injury or ADHD evaluations)?

☐ No ☐ Yes:

Psychologist / Facility	Start Date	End Date

Have you ever been hospitalized for your mental health?

☐ No ☐ Yes:

Hospital / Facility	Start Date	End Date
Hospital / Facility	Start Date	End Date

Have you ever attempted to harm yourself in the past? (Suicide attempt, Self-harm or "cutting")? ☐ No ☐ Yes
If yes, please provide details. i.e., how many times, last attempt date, means (gun, knife, pills, etc.) location, did you go to the hospital, cut on thighs/arms/etc.

____

____

Do you have any history of being physically, sexually, or emotionally abused? ☐ No ☐ Yes (please share what type to your comfort level here):

____

Do you have any history of witnessing traumatic events, including domestic violence? ☐ No ☐ Yes (please describe to your comfort level here):

____

Were you ever placed in someone else's care other than that of your parents/guardians (i.e., social service removal}? ☐ No ☐ Yes (please describe here to your comfort level):

____

Are you Sexually Active? ☐ No ☐ Yes

Sexuality: ☐ Heterosexual ☐ Bisexual ☐ Gay, Lesbian, Trans ☐ Asexual ☐ Questioning

Current Relationship Status: (check all that apply)
☐ Single ☐ In a relationship ☐ Married ☐ Separated ☐ Divorced ☐Widowed

Do you have any children (biological or adopted)? ☐ No ☐ Yes:
If yes, how many and what are their ages, names, and sex (i.e., male or female)

____

____

Please list everyone currently living in your home (i.e., spouse, children, roommate):

____

____

What do you like to do in your free time (hobbies or other interests)?

____

____

Employer / School: ____

Highest grade level / degree attained: ____

Did you have to participate in any "Special Education" classes for any learning disabilities or disorders? ☐ No ☐ Yes

(Please describe) ____

Any history of repeating a grade(s)? ☐ No ☐ Yes (which grades) _________________________

Any recent change in academic or work performance? ☐ No ☐ Yes (Please describe how or in what way):

____

Do you often have problems with friendships or relationships? ☐ No ☐ Yes (Please describe):

____

Have you had, or currently have, any court proceedings or problems with law enforcement? ☐ No ☐ Yes:

if yes, please describe: ____

Have you been arrested in the past? ☐ No ☐ Yes:

if yes, please describe: ____

Do you use any drugs, including alcohol, nicotine and/or illicit drugs? ☐ No ☐ Yes
If yes, what kind of drug, how much of the drug, how often, how long have you been using it, and last use:

____

____

Are you currently in any Medication Assisted Therapy (MAT) treatment program for substance abuse – or receiving Buprenorphine and Naloxone (Suboxone)like products or Naltrexone (Vivitrol)for a opioid, alcohol, or other substance abuse disorder?

 No Yes: ______________________________ ____________ ____________
Hospital / Facility Start Date End Date

Have you ever used illicit drugs in the past? No Yes
If yes, what kind of drug, how much of the drug, how often, how long did you use it, and when was the last use:

____

____

Describe your Alcohol use (check all that apply): Not at all Only in social settings Every day/evening
 Every weekend Less than two or three times a week When I am stressed
 When I am bored When I am depressed To help me sleep When I wake up

Describe your Cannabis use (check all that apply): Not at all Only in social settings Every day/evening
 Every weekend Less than two or three times a week When I am stressed
 When I am bored When I am depressed To help me sleep When I wake up

Have you ever participated in a substance abuse program? No Yes
If yes, please list type of program name, inpatient / outpatient, dates attended and if program was completed

____

____

Do you have any blood-related family members (parents, grandparents, siblings, aunts/uncles, or immediate cousins) with a history of major depression, severe anxiety, mood disorders (i.e., bipolar, manic -depressive, mania), schizoaffective, schizophrenia, cognitive disorders, intellectual disabilities, Substance abuse, and/or any other mental health disorders you are aware of? (Please list separately whether the family member is on your mother's side or your father's side of the family)

Maternal: No maternal family mental health problems known
 Yes, (please list the relative and mental health problem/disorder (i.e., Mother – Depression)

____

____

Paternal: No paternal family mental health problems known
 Yes, (please list the relative and mental health problem/disorder (i.e., Uncle – Schizophrenia)

____

____

Is there a history of Suicide or suicide attempts by any family members? No Yes:
If yes, please indicate family member and side of family, approximate date):

____

____

Medications:

Do you have any known allergies to medications or foods? □ No □ Yes:
If yes, list the drug name and type of reaction (i.e., Penicillin – Swelling):

____

____

Please list all **psychiatric medications** you have been prescribed for your mental health -starting with the most recent. □ Not Applicable

List most recent medication(s) first: highest dose / frequency / how long taken / prescribed by:

(For example: Buspar, 10mg, 1 tablet 3 times a day for 1 year) mark type- □ Psychiatrists / Mental Health NP ✖Primary care provider □ Other

____ □ Psychiatrists / Mental Health NP □Primary care provider □ Other

____ □ Psychiatrists / Mental Health NP □Primary care provider □ Other

____ □ Psychiatrists / Mental Health NP □Primary care provider □ Other

____ □ Psychiatrists / Mental Health NP □Primary care provider □ Other

____ □ Psychiatrists / Mental Health NP □Primary care provider □ Other

∗Please provide any additional information on psychiatric medication(s) prescribed to you in the "additional notes" section below.

Have your previous psychiatric medications been helpful? Did you have any side effects? Why did you stop taking them?

____

____

Are you currently taking any medications prescribed by another doctor? □ No □ Yes:

Medication(s): dose / frequency	When Started	Prescribing doctor
(i.e., Baby Aspirin 81 mg, 1 tablet every day ----1 year----- Dr..Feelbetter)		

Are you taking any supplements or vitamins? □ No □ Yes: (Please list below)

____

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Please continue lists of medications, or any other additional information you feel is relative to your mental health in the space below:

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Past Medical History:

Do you have - or have you had - any problems with the following ***Chronic Health Problems, Body / Organ systems***, below? If, yes, please describe date diagnosed, treatments used (medication/surgery/diet/etc.), or any other important details – if more room is needed, please enter it into the "Additional Medical Notes" section below):

Chronic Health Problems:

Diabetes: No ☐ Yes: ☐Type I or II: __________ How long: _____________ Treatment used: _____________
High blood Pressure ☐ No ☐ Yes: How long: _____________ Treatment used: _____________
Low blood Pressure ☐ No ☐ Yes: How long: _____________ Treatment used: _____________
Heart Disease: ☐ No ☐ Yes: How long: _____________ Treatment used: _____________
Kidney Disease: ☐ No ☐ Yes: How long: _____________ Treatment used: _____________
Liver Disease: ☐ No ☐ Yes: How long: _____________ Treatment used: _____________
High Cholesterol: ☐ No ☐ Yes: How long: _____________ Treatment used: _____________
GERD (reflux disease): ☐ No ☐ Yes: How long: _____________ Treatment used: _____________
COPD (Chronic Obst. Pulm. Dz.): ☐ No ☐ Yes: How long: _____________ Treatment used: _____________
Pancreatitis: ☐ No ☐ Yes: How long: _____________ Last Episode: _______________
Autoimmune Disorders: ☐ No ☐ Yes: How long: _____________ Treatment used: _____________
HIV: ☐ No ☐ Yes: How long: _____________ Treatment used: _____________
Hepatitis: ☐ No ☐ Yes: How long: _____________ Treatment used: _____________

Is Chronic Pain (unstoppable pain lasting longer than 6 months) a problem for you: ☐ No ☐ Yes:

How long: ____
Location of pain: ____
What caused the pain to start? ____
How do you decrease your pain? ____
What treatments have you, or are you using? (i.e., pain clinic – injections, medications, surgery, mediation, etc.)
____
____

Does chronic pain effect your daily life? ☐ No ☐ Yes: (if yes, explain how):
____
____

Body / Organ Systems:

Do you have problems with any of the body or organ systems below? If so, please further explain.

Eyes: ☐ No ☐ Yes: (Please explain) ____
Ears: ☐ No ☐ Yes: (Please explain) ____
Nose: ☐ No ☐ Yes: (Please explain) ____
Mouth: ☐ No ☐ Yes: (Please explain) ____
Throat: ☐ No ☐ Yes: (Please explain) ____
Lungs: ☐ No ☐ Yes: (Please explain) ____
Smoker: ☐ No ☐ Yes: (How many packs/ how many years) __________________________
Heart: ☐ No ☐ Yes: (Please explain) ____
History of Chest pain: ☐ No ☐ Yes: (Please explain) ____________________________
Vascular ☐ No ☐ Yes: (Please explain) ____
Gastro Intestinal: ☐ No ☐ Yes: (Please explain) __________________________________
Genitourinary: ☐ No ☐ Yes: (Please explain) ____________________________________
Neurological: ☐ No ☐ Yes: (Please explain) ____________________________________
History of Stroke: ☐ No ☐ Yes: (Please explain) ______________________________
History of Seizures: ☐ No ☐ Yes: (Type of seizure and date of last) ________________

History of Head Injury with Loss of consciousness: □ No □ Yes: (Please explain)
____

Skeletal: □ No □ Yes: (Please explain) ____

History of Arthritis: □ No □ Yes: (Please explain) ______________________________

Integumentary / Skin: □ No □ Yes: (Please explain) ______________________________

Liver: □ No □ Yes: (Please explain) ____

Kidney: □ No □ Yes: (Please explain) ____

Pancreas: □ No □ Yes: (Please explain) ______________________________________

Thyroid: □ No □ Yes: (Please explain) ______________________________________

Cholesterol: □ No □ Yes: (Please explain) ____________________________________

Female:

Are you? □ Premenopausal □ Perimenopausal □ postmenopausal

Do you use birth control? □ No □ Yes: (Type) ______________________________

Is your menses (period) regular? □ Yes □ No: (Please explain if not) ________________

Date of last menstrual period: ______________

Number of Pregnancies: ____________

Number of miscarriages: ____________

Have you had a Hysterectomy? □ No □ Yes: □ Total Hysterectomy □ Partial Hysterectomy

Do you have a history of PCOS? □ No □ Yes: (How long and how is it being treated)

____

Do you have any sexual function concerns? □ No □ Yes: (Please explain)

____

Male:

Prostate Problems: □ No □ Yes: (Please explain) ______________________________

Problems with Erectile Dysfunction: □ No □ Yes

Do you have any sexual function concerns? □ No □ Yes: (Please explain)

____

Do you follow any special diet? □ No □ Yes: (Please explain type of diet and reason)

____

Do you have any bleeding / clotting disorders or take medications to thin your blood? □ No □ Yes: (Please explain)

____

Do you have frequent Infections / wounds /sores? □ No □ Yes: (Please explain what type / location)

____

Have you ever passed out or fainted? □ No □ Yes (please provide details):

____

Have you ever been hospitalized overnight for any reason? □ No □ Yes (please provide details and dates):

____

____

Have you had any major surgeries or accidents requiring medical treatment (fall, car accident, etc.) in the past?
□ No □ Yes (please provide details):

____

____

Have you ever had an x-ray, computerized axial tomography (CAT) or magnetic resonance imaging (MRI) scan of your head: □ No □ Yes (please list for what reason and date):

____

____

Do you have any history of blood-related family members (parents, grandparents, siblings, aunts/uncles, or immediate cousins) having a medical history of diabetes, heart disease, types of cancer, high blood pressure, obesity, Kidney or liver disease – or common health problems within your family – that you are aware of? (Please list separately whether the family member is on your mother's side or your father's side of the family)

Maternal: □ No, there are no known common medical problems on my mother's side of the family.
□ Yes, my mother side of the family had common medical problems (please give details):
(i.e., heart disease – mother, grandmother, 2 aunts)

____

____

Paternal: □ No, there are no known common medical problems on my father's side of the family.
□ Yes, my father's side of the family had common medical problems (please give details):
(i.e., heart disease – father, uncle: Diabetes – father, grandfather: etc.)

____

____

Additional Medical Notes: This space left open for any additional notes or medical information for the questions listed above, or any additional notes the patient would like to communicate to their provider about their medical information.

____

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HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: December 30, 2021

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices ("Notice") apply to Insight Behavioral Health Associates, S. Corp, its affiliates and its employees. Insight Behavioral Health Associates will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by Insight Behavioral Health Associates. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA"). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address below.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.
Uses and Disclosures for Payment: We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment.
Uses and Disclosures for Health Care Operations: We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving clinical treatment and patient care.
Individuals Involved in Your Care: We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.
Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.
Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below.
Research: In limited circumstances, we may use and disclose your protected health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board which oversees the research or by representations of the researchers that limit their use and disclosure of your information.
Fundraising: We may use your information to contact you for fundraising purposes. We may disclose this contact information to a related foundation so that the foundation may contact you for similar purposes. If you do not want us or the foundation to contact you for fundraising efforts, you must send such request in writing to the Privacy Officer at the address below.
Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- Any purpose required by law;
- Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health

investigations;
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect ordomestic violence;
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
- To your employer when we have provided health care to you at the request of your employer;
- To a government oversight agency conducting audits, investigations, civil or criminal proceedings;
- Court or administrative ordered subpoena or discovery request;
- To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- To coroners and/or funeral directors consistent with law;
- If necessary to arrange an organ or tissue donation from you or a transplant for you;
- If you are a member of the military, we may also release your protected healthinformation for national security or intelligence activities; and
- To workers' compensation agencies for workers' compensation benefit determination.

DISCLOSURES REQUIRING AUTHORIZATION:

Psychotherapy Notes: We must obtain your specific written authorization prior to disclosing any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following: (1) tocarry out certain treatment, payment or healthcare operations (e.g., use for the purposes of your treatment, for our own training, and to defend ourselves in a legal action or other proceeding brought by you), (2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law, (3) asrequired by law, (4) for health oversight activities authorized by law, (5) to medical examiners or coroners as permitted by state law, or (6) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public.
Genetic Information: We must obtain your specific written authorization prior to using or disclosing your genetic information for treatment, payment or health care operations purposes. We may use or disclose your genetic information, or the genetic information of your child, without your written authorization only where it would be permitted by law.
Marketing: We must obtain your authorization for any use or disclosure of your protected health information for marketing, except if the communication is in the form of (1) a face-to-face communication with you, or (2) a promotional gift of nominal value.
Sale of Protected Information: We must obtain your authorization prior to receiving direct or indirect remuneration in exchange for your health information; however, such authorization is not required where the purpose of the exchange is for:
- Public health activities;
- Research purposes, provided that we receive only a reasonable, cost-based fee to cover the cost to prepare and transmit the information for research purposes;
- Treatment and payment purposes;
- Health care operations involving the sale, transfer, merger or consolidation of all or part of our business and for related due diligence;
- Payment we provide to a business associate for activities involving the exchange of protected health information that the business associate undertakes on our behalf (or the subcontractor undertakes on behalf of a business associate) and the only remuneration provided is for the performance of such activities;
- Providing you with a copy of your health information or an accounting of disclosures;
- Disclosures required by law;
- Disclosures of your health information for any other purpose permitted by and in accordance with the Privacy Rule of HIPAA, as long as the only remuneration we receive is a reasonable, cost-based fee to cover the cost to prepare and transmit your health information for such purpose or is a fee otherwise expressly permitted by other law; or
- Any other exceptions allowed by the Department of Health and Human Services.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION:

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You may obtain an "IBHA Expanded Release of Information" form" from the front office person. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies, you will be charged a fee for copying and postage.
Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests, must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.
Accounting for Disclosures of Your Protected Health Information: You have the right to receive an accounting of certain disclosures made by us of your protected health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.
Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests, but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health informationpertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid Insight Behavioral Health Associates in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as we appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records.
Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or

potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Officer at the address below.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at the below address. There will be no retaliation for filing a complaint.

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201
or call: (800) 368-1019
or email: OCRComplaint@hhs.gov

For Further Information: If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the Insight Behavioral Health Associate's Safety, Security, Privacy, Officer (SSPO) by phone at (859) 209-2198 or at the following address: Attn: Safety, Security, and Privacy Officer, 1000 E. Lexington Ave. Ste. 30, Danville, KY. 40422.

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1000 E. Lexington Ave. Ste. 30
Danville, KY. 40422
Ph. (859) 209-2198 Fax: (859) 209-4439

No Surprises Act Notice

Effective Date: January 1, 2022

Definitions / Notes:
- IBHA - Insight Behavioral Health Associates
- The terms patient / client is used interchangeably and is a consumer of IBHA services.
- GFA – Good Faith Estimate

The *No Surprises Act* is a federal law that was enacted December 27, 2021 and took effect January 1, 2022.
The purpose of the *no surprises act* is to protect patients from surprise medical bills and established several new rules for providers, facilities, and providers of air ambulance services.

The law requires providers and/or facilities to inform certain patients of their care costs in order to promote transparency and no surprise medical bills. Those patients include individuals electing to self-pay for their services or those enrolled in group health plans, group or individual health insurance coverage, and Federal Employees Health Benefits plans. For those clients, federal law requires us to extend additional disclosures regarding your costs and dispute resolutions. **However, the law requiring such disclosures do not apply to those who have coverage through programs like Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE, as these programs have other protections against high medical bills**.

For those patients enrolled in group health plans, group or individual health insurance coverage, and Federal Employees Health Benefits plans, IBHA, and its providers, must inform you -through this notice- that balance billing (where a patient is charged the difference between an out-of-network provider's cash-pay rate and any payments from the patient's insurer) is prohibited – unless consent from the client is obtained to collect the unpaid balance portion of a claim (very rare cases). This does not apply to any cost sharing benefits such as Co-pays or unmet deductibles. IBHA does not use a "balanced billing method" because we use the contracted rates established by your insurance company and IBHA; and, all co-pays and deductibles are collected on the day of services so there should be no outstanding bills.

For those who are Uninsured, shopping for care, or self-pay, IBHA is required to inform you of the cost of your care (typically discussed upon making an appointment), but also, IBHA will extend to you the option of viewing our full fee-for-services schedule, in our office, for full transparency.

We must also inform you that you have the right to request a Good Faith Estimate (GFE) of your care. A GFE is a standardized document completed by IBHA that helps to detail the expected costs of your expected care. This form takes many factors into consideration and is not immediately available. The law requires a GFE to be provided within 3 business days upon request. Information regarding scheduled items and services must be furnished within 1 business day of scheduling an item or service to be provided in 3 business days; and within 3 business days of scheduling an item or service to be provided in at least 10 business days.

Notice. If a GFE is produced, the estimates are based on the typical course of the disorder, and so may not be able to reflect the full costs involved – and so full costs are relative to the fluctuating severity of the disorder, and the frequency of services sought by the patient. The patient and/or their representative shall be mindful of any GFE produced and initiate the resolution process as outlined in the GFE given to the client, once the GFE is surpassed.

If you have health insurance and you elect to self-pay – because of the laws, IBHA requires the patient or their representative to sign a separate document titled "*Surprise Billing Protection Form*" stating that the client/representative are self-pay, and will not retroactively request any reimbursement from any type of insurance coverage.

Dispute Resolutions of Good Faith Estimates (GFEs):
You may contact IBHA or its provider(s) to let them know the billed charges are higher than the GFE you received. You can ask IBHA to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.
You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS) if the disputed amount is greater than the GFE by $400. If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises.