Guinn . . . dedicated to helping the people we serve have a better life
HEALTHCARE TECHNOLOGIES, LLC

Patient Copy - 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.

1. **Purpose:** Guinn Healthcare Technologies, LLC (GHT. LLC) and its professional staff, employees, and volunteers and all of its affiliated entities follow the privacy practices described in this Notice. GHT, LLC maintains your medical information in records that will be maintained in a confidential manner, as required by law. However, GHT, LLC must use and disclose your medical information to the extent necessary to provide you with quality health care. To do this, GHT, LLC must share your medical information as necessary for treatment, payment and health care operations.

2. **What Are Treatment, Payment, and Health Care Operations?** Treatment includes sharing information among health care providers involved in your care. For example, your counselor may share information about your condition with the clinical supervisor to discuss treatment approaches, or in order to make a diagnosis. GHT, LLC may use your medical information as required by your insurer, HMO or other reimbursement system to obtain payment for your treatment. We also may use and disclose your medical information to improve the quality of care, for example, for review and training purposes.

3. **How Will GHT, LLC Use My Medical Information?** Your medical information may be used or disclosed, unless you ask for restrictions on a specific use or disclosure, for the following purposes:
   - Family members or close friends who may consent to your treatment or who are involved in the payment for your treatment.
   - American Red Cross (or a government disaster relief agency) if you are involved in a disaster relief effort.
   - Appointment reminders.
   - To inform you of treatment alternatives or benefits or services related to your health that may be of interest to you. (You will have an opportunity to refuse to receive this information).
   - As required by law.
   - Public health activities, including disease prevention, injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect or domestic violence (if you agree or as required or authorized by law).
   - Health oversight activities, *e.g.,* audits, inspections, investigations, and licensure.
   - Lawsuits and disputes. (We will attempt to provide you advance notice of a subpoena before disclosing the information).
   - Law enforcement *(e.g.,* in response to a court order or subpoena).

- To coroners and medical examiners.
- To prevent a serious threat to health or safety.
- To military command authorities if you are a member of the armed forces.
- National security and intelligence activities.
- Protection of the President or other authorized persons for foreign heads of state, or to conduct special investigations.
- To carry out treatment, payment, and health care operations functions through business associates, *e.g.,* to install a new computer system.
- Alcohol and drug abuse information has special privacy protections. GHT, LLC will not disclose any information identifying an individual as being a patient or provide any medical information relating to the patient's substance abuse treatment unless: (i) the patient consents in writing; (ii) a court order requires disclosure of the information; (iii) medical personnel need the information to meet a medical emergency; (iv) qualified personnel use the information for the purpose of conducting scientific research, management audits, financial audits, or program evaluation; or (v) it is necessary to report a crime or a threat to commit a crime, or to report abuse or neglect as required by law.
- Certain types of information may be subject to additional restrictions on disclosure, such as AIDS test results and psychotherapy notes.

4. **Your Authorization Is Required for Other Disclosures.** Except as described above, we will not use or disclose your medical information unless you authorize (permit) GHT, LLC in writing to disclose your information. You may revoke your permission, which will be effective only after the date of your written revocation.

5. **You Have Rights Regarding Your Medical Information.** You have the following rights regarding your medical information, provided that you make a written request to invoke the right on the form provided by GHT, LLC:

6. **Right to request restriction.** You may request limitations on your medical information we use or disclose for health care treatment, payment, or operations *(e.g.,* you may ask us not to disclose that you have had a particular procedure), but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

7. **Right to confidential communications.** You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted.

8. **Right to inspect and copy.** You have the right to inspect and copy your medical information regarding decisions about your care. We may charge a fee for copying, mailing and supplies. Under limited circumstances, your request may be denied; in some cases you may request review of the denial by another licensed health care professional chosen by GHT, LLC. GHT, LLC will comply with the outcome of the review.

9. **Right to request amendment.** If you believe that the medical information we have about you is incorrect or incomplete, you may request an amendment on the form provided by GHT, LLC, which requires certain specific information. GHT, LLC is not required to accept the amendment.

10. **Right to accounting of disclosures.** You may request a list of the disclosures of your medical information that have been made to persons or entities in the past six years, but not prior to April 14, 2003 (such list will not include disclosures made pursuant to an authorization or for treatment, payment, and health care operations). After the first request, there may be a charge.

11. **Right to a copy of this Notice.** You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy.

12. **Requirements Regarding This Notice.** GHT, LLC is required by law to provide you with this Notice. We will be governed by this Notice for as long as it is in effect. GHT, LLC may change this Notice and these changes will be effective for medical information we have about you as well as any information we receive in the future. Each time you register at GHT, LLC for behavioral health care services, you may receive a copy of the Notice in effect at the time.

13. **Complaints.** If you believe your privacy rights have been violated, you may file a complaint with the Director of Guinn Healthcare Technologies, LLC – 5725 Overridge Drive, Arlington, Texas 76017 – 817 505-1407, or with the Office for Civil Rights, U.S. Department of Health & Human Services, 1301 Young Street - Suite 1169, Dallas, TX 75202, (214) 767-4056; (214) 767-8940 (TDD), (214) 767-0432 FAX. You will not be penalized or retaliated against in any way for making a complaint to Guinn Healthcare Technologies, LLC or the Office for Civil Rights, U.S. Department of Health & Human Services.

Contact: Guinn Healthcare Technologies, LLC at 817/505-1407 if:

- you have a complaint;
- you have any questions about this Notice;
- you wish to request restrictions on uses and disclosures for health care treatment, payment, or operations; or
- you wish to obtain a form to exercise your individual rights described in paragraph 5.

This notice version effective 1-28-08

Patient Copy - Informed Consent to Behavioral Health Treatment and Procedures

You have the right as a patient to be informed about your condition and give your consent to treatment. In order to consent to treatment you must be an adult (age 18 or over or have the “disabilities of minor” removed) and have the ability to understand and appreciate the nature and consequences of a decision regarding behavioral health treatment and the ability to reach an informed decision in the matter. You have participated in an initial interview, screening and/or assessment for social, emotional and psychological conditions and discussed the findings with your counselor. This consent form is designed to provide a written confirmation of such discussions by recording some of the more significant information given to you. It is intended to make you better informed so that you may give or withhold your consent to the proposed procedure(s).

1. **Condition:** My counselor has explained to me that I appear to have condition(s) symptomatic of a mental disorder.

2. **Proposed Procedure(s):** I understand that the procedure(s) proposed for evaluating and treating my condition is/are: participation in a clinical interview and

structured diagnostic assessment to further define the need or problems to be addressed, and potentially participation in one or more of the following activities: counseling sessions, case management, peer support, treatment/case management planning sessions, activities designed to assist me in achieving self sufficiency and/or permanent housing or other outcomes.

3. **Risks/Benefits of Proposed Procedure(s):**
   A. Some of the potential benefits of the treatment and procedures proposed are: Improved mood, improved ability to function in important social relationships, improved ability to achieve self sufficiency and stable housing, improved ability to cope with stress, reduced emotional distress, improved access to supports and services.
   B. Just as there may be benefits to the proposed treatment and procedures, I also understand the recommended treatment and procedures involve risks. These risks include recalling or re-experiencing unpleasant memories and feelings, the possibility of increased stress related to participating in counseling, the possibility that my need for treatment may be more long-term than the program can provide, I could be involved in an auto accident or other accident if I am being provided transportation assistance from program staff, the confidentiality of my circumstances or treatment could be inadvertently revealed.

4. **Complications; Unforeseen Conditions; Results:** I am aware that in the practice of counseling, other unexpected risks or complications not discussed may occur. I also understand that during the course of the proposed treatment and procedure(s) unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment.

5. **Acknowledgments:** The available alternatives, some of which include psychiatric treatment with medication, peer support or other non-professional assistance; assistance in a faith based support program may provide some of the same benefits. The benefits of these alternatives in a less structured approach to treatment and the potential for longer term involvement. I understand what has been discussed with me as well as the contents of this consent form, and have been given the opportunity to ask questions and have received satisfactory answers.

6. **Consent to Procedure(s) and Treatment:** Having read this form and talked with the counselors and case managers, my signature below acknowledges that: I voluntarily give my authorization and consent to the performance of the procedure(s) described above by my counselor and/or his/her trained associates.