



Welcome!

We appreciate the confidence you have placed in us, and look forward to serving your psychiatric needs. We are aware you have options in pursuing psychiatric care and want you to know we are dedicated to providing the highest quality care.

With the many administrative and legal demands on the practice of medicine, our office has developed policies and procedures that enable us to continue serving our clients at the highest level of care.

Our hope is that in reading the enclosed information, you will further understand how to navigate the complicated medical world as it relates to your time in our care. Please take the time to read them carefully and should you have any questions or concerns we would be happy to take the time to talk with you at our first meeting.

Thank you in advance for your attention to the enclosed information, but most of all, for your trust and confidence in choosing Mind Therapy Clinic to provide your care. We look forward to meeting you.

Sincerely,

Your Care Team at Mind Therapy Clinic

POLICIES

Appointments

Appointments are generally scheduled for half-hour, hour, and one and a half hour time periods. This includes 20, 50, and 80 minutes of face-to-face time with a clinician, and 10 minutes in which the clinician completes charts, paperwork and phone calls. We make an effort to stay on schedule to be fair to everyone and provide the best service.

It is important for you to be on time for your appointment and to complete all paperwork at initial visits, as your appointment will still need to end on schedule. Lateness may require scheduling an additional appointment to complete necessary work.

Paperwork

Our paperwork is available online on our website: www.mindtherapyclinic.com/clients. We can also send out paperwork to you by mail or email after you schedule the initial appointment so you have time to gather all appropriate information before your first visit. The completion of these forms before you come to our office is of great importance. It is imperative that we have your clinical data and exact medication history in order for us to address your needs. By having your history completed beforehand, we are able to spend our limited time together in the most effective and efficient manner. We understand that there is a lot of information we are asking for and we appreciate your efforts to provide us with a thorough and accurate history. Incomplete paperwork may prevent us from completing the initial evaluation in one session and may require that you return again to complete the appointment. Please complete the entire package before your appointment and bring it with you.

Prescription Refills

Typically, your provider writes prescriptions for the amount of medication needed until your next scheduled appointment. Patients who require refills should request their pharmacies to send an electronic or fax request for refills to our office. Please make this request at least **five (5) business days** prior to running out of medication. Please call for refills during regular office hours.

Cancellation Policy

We require **two (2) business days** notice on all cancellations except for medication management appointments. We require **one (1) business day** notice on medication management appointments. **One (1) week notice** must be given when cancelling ongoing enrollment in any group therapy. Cancellation request during trial period for group therapy requires **one (1) business day** notice. Any requests for leave of absence must be submitted in writing, and signed and dated **one (1) week** prior to the first date of absence. An agreement regarding this policy - late appointments, cancelled late or missed for any reason - will be signed by you. **It is our policy that the time lost by the clinician, not the reason for the cancellation, is what determines a charge.**

Insurance

Mind Therapy Clinic is a fee-for-service practice. As such, we do not contract with any insurance plans. While this may seem unusual for many, we feel that this is in the best interests of our patients. Medical care should be a partnership between a patient and a physician or other clinician. Insurance companies often try to influence and control the nature of the care provided. They frequently place unreasonable constraints on treatment options and even the amount of time that clinicians spend with patients.

In addition, accepting insurance would require greater administrative resources that detract from the time that our clinicians can spend with their patients. In particular, given our comprehensive, integrative treatment plans, we would find ourselves spending too much time attempting to obtain insurance approval for each of the treatment options.

Non-Visit Charges

We are frequently asked to call insurers, call for prior authorization for medications, prepare letters and reports, and other services outside of regular appointments. We are happy to do so. However, many of these services can take a considerable amount of time. For instance a call to an insurer for prior authorization for a medication can often take as much as twenty minutes. For any such services requiring more than about five minutes of a clinician's time, you will be charged based upon the amount of time spent by the clinician.

Non-Covered Charges

A statement of charges and payments will be provided to you. This statement will be coded so you may submit it to your insurance carrier for possible reimbursement. Please realize that some charges for services may not be covered by your insurance policy. These may include, but are not limited to: some diagnostic testing; neurofeedback treatment; some telephone calls or emails to a patient for consultation or medical management; intervention for medical management purposes on a patient's behalf with agencies, employers or insurance companies, including preauthorization for non-formulary medications; psychiatric evaluation of records, reports and other data for medical persons; preparation of reports for other physicians, agencies, insurance carriers, or attorneys; and missed appointment fees.

Communication with Other Clinicians

We have found it is a helpful and important component of mental health care that we communicate and coordinate with other healthcare professionals involved in your care, particularly psychotherapists and primary care physicians. To do this, we need you to sign the attached Consent for Release of Confidential Information to Primary Care Physicians and/or Referring Practitioners.

Our service to you is important to us. We appreciate respectful and constructive feedback and look forward to working together with you.

PATIENT ACKNOWLEDGEMENT

CANCELLATION POLICY

Scheduled appointment times are reserved for you. All appointments are subject to full charge, whether missed, unattended or cancelled. This charge can be avoided by giving two (2) business days' notice. In order to avoid being charged the full amount of the appointment you must call by 5 p.m. at least two (2) business days prior to the appointment day (i.e., if your appointment is anytime on Monday you must call to cancel by 5 p.m. on the prior Thursday). Medication management visits require one (1) business day's notice. Group therapy is charged on a monthly basis, and the payment for the first month is due at the time of enrollment. Cancellation request during trial period for group therapy requires **one (1) business day** notice. **One (1) weeks' advance notice is required** to cancel enrollment in any group. Any requests for leave of absence must be submitted in writing, and signed and dated **one (1) week** prior to the first date of absence. Unexcused missed group sessions are not refunded. You acknowledge that Insurance companies do not pay for cancellation fees and, and these charges are your responsibility. Repeated "no show" appointments could result in treatment ending for non-compliance.

(Initial)

RETURNED CHECKS

There will be a \$35.00 service charge applied to your account for all returned checks.

(Initial)

DELINQUENT ACCOUNTS

Should your account become 60 days delinquent, finance charges of one and one half percent (1.5%) per month may be added to your bill. Services may be discontinued, your bill may be turned over to a collection agency and you will be responsible for payment of all legal and all other collection costs.

(Initial)

LIMITATIONS OF CONFIDENTIALITY STATEMENT

Information obtained by Mind Therapy Clinic relating to the client is strictly confidential. Mind Therapy Clinic clinicians share confidential mental health information only with other healthcare providers involved in the client's treatment in order to provide integrated, comprehensive care. There are legal exceptions to when such information may be shared with third parties, such as (1) in medical emergencies; (2) if the client presents as a physical danger to self or others; (3) if child or elder abuse and/or neglect is suspected; or (4) if the client authorizes the release of the information with a signature. For more information on how health information may be used or disclosed by Mind Therapy Clinic, please refer to our Notice of Privacy Practices.

(Initial)

MOBILE PHONES, INSTANT MESSAGES, FAXES, EMAIL, VIDEO CHATS

Mobile phone, instant messages, video chats, and email communication may not be secure. Faxes can also be easily sent to erroneous numbers. If you are using a cell phone while communicating with our office, you must be aware that we cannot ensure the confidentiality of the call. If you use email to communicate with Mind Therapy Clinic then we will assume that you have made an informed decision that you are taking the risk of such communication being intercepted. Please do not communicate an emergency by email or fax.

(Initial)

MESSAGES

It may be necessary at times for our office to leave you a message at the phone number(s) you provide us. By supplying us with specific phone numbers, you authorize us to leave messages for you at those numbers.

(Initial)

EMERGENCY ACCESS

We try to service our clients whenever possible; however we are not a 24-hour facility. In case of an emergency, call 911 or go to the nearest emergency room.

(Initial)

CONSENT FOR TREATMENT

I authorize and request my practitioner to carry out psychological exams, treatment and/or diagnostic procedures, which now, or during the course of my treatment, become advisable. I understand the purpose of these procedures will be explained to me upon my request and that I am responsible for the costs of such exams and/or diagnostic procedures. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me. I understand and acknowledge that from time to time I may have a phone or video session. I authorize these sessions.

(Initial)

ELECTRONIC RECORD KEEPING SYSTEM

Mind Therapy Clinic uses Electronic Medical Records (EMR) to securely maintain your health care information. Electronic Medical Record means an electronic record of health-related information that: includes my demographic and clinical health information, such as medical history and problem lists; and has the capacity: to provide clinical decision support; to support physician entry and billing invoices; to capture and query information relevant to healthcare quality; and to communicate with me through patient portal about my care. By initialing here, I understand that my healthcare information is maintained in this way.

(Initial)

BILLING

Itemized billing statements are available through a secure patient portal website, and my unique

access is available when I activate the online account assigned to me. If I do not create an account, it is my responsibility to request the billing statement to be mailed to me. An invoice will be placed in my secure portal for any unpaid balance. If the invoice remains unpaid for 120 days, my account will be in default and auto referred to a collection agency. The balance of any account not paid within 60 days will begin to accrue interest at the rate of 1.5% per month or the maximum allowed by applicable law, whichever is lower.

If I do not agree with the billing provided in my billing statement, I understand that I have thirty (30) days from the date of the statement to report errors or objections. If there are problems with my account, it is my responsibility to contact Mind Therapy Clinic to address the problem or to discuss a workable solution. If a workable solution cannot be reached, I agree to the arbitration process administered by the American Health Lawyers Association (AHLA) Dispute Resolution Service and conducted pursuant to the AHLA Rules of Procedure for Arbitration. Judgment on the award may be entered and enforced in any court having jurisdiction. In the event of a legal action to enforce the terms of this Agreement, including collection of amounts payable or Mind Therapy becomes party to any legal proceedings relating to my treatment at Mind Therapy Clinic, Mind Therapy Clinic shall be entitled to payment from me or my Guarantor of its reasonable attorney's fees and costs, including any collection costs.

(Initial)

USE OF INFORMATION RELATED TO MY TREATMENT

I give permission to Mind Therapy Clinic and its business associates to use my information if it relates to my treatment.

(Initial)

PATIENT AGREEMENT

I have been notified by Mind Therapy Clinic of my responsibility for cancellation policy/fees. I authorize release of information to my Primary Care Physician, psychotherapist, psychiatrist, other healthcare providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. I authorize the release of necessary information to a collection agency should that become necessary.

Patient Signature or Parent/Guardian signature if patient is a minor

Date

FINANCIAL AGREEMENT

This Financial Agreement (the "Agreement") is made by and between the undersigned Client, and if applicable, Guarantor (individually or collectively the "Responsible Party") and Mark J. Schiller PC, DBA Mind Therapy Clinic ("Mind Therapy Clinic"). Responsible Party agrees that in consideration for Client's receiving certain treatment services as described herein, Responsible Party assumes full financial responsibility for the charges relating to such services provided to the Client.

Responsible Party shall be responsible for any amounts due for any amenities or services Client receives from Mind Therapy Clinic. These charges are due at the time of service. Mind Therapy Clinic will bill Responsible Party directly for any balances due, including, but not limited to, charges unpaid or missed appointments. If Responsible Party fails to make payment on any balances due or make satisfactory payment arrangements with Mind Therapy Clinic for any balance due, Mind Therapy Clinic may turn Client's account over to a collection agency or take legal actions pursuant to any breach of this Agreement. Any such collection efforts may necessitate that Mind Therapy Clinic, or its designee, request financial and credit information from various sources including, without limitation, credit reporting bureaus.

Any checks returned for non-payment will automatically be charged to Client's account including a \$35 service charge.

Other than any collection action, which may be pursued by Mind Therapy Clinic before any court with jurisdiction over Client and/or Guarantor, any dispute arising out of or relating to this Agreement, Client's treatment by Mind Therapy Clinic or the subject matter hereof, including any dispute regarding the scope of this clause, will be resolved exclusively through arbitration administered by the American Health Lawyers Association Dispute Resolution Service and conducted pursuant to the AHLA Rules of Procedure for Arbitration. Judgment on the award may be entered and enforced in any court having jurisdiction. In the event Client, Guarantor or Mind Therapy Clinic initiates any legal action to enforce the terms of this Agreement, including collection of amounts payable hereunder, or Mind Therapy Clinic becomes party to any legal proceeding relating to Client's treatment by Mind Therapy Clinic, Mind Therapy Clinic shall be entitled to payment from Responsible Party of its reasonable attorney's fees and costs, including any collection costs.

To the greatest extent permitted by applicable law Responsible Party (a) agrees to indemnify, defend and hold harmless Mind Therapy Clinic and its agents, officers, shareholders contractors and employees ("Released Parties") from and against any action arising out of or related to Client's treatment by Mind Therapy Clinic and (b) waives, releases and discharges any of the Released Parties from any liabilities associated with Client's treatment by Mind Therapy Clinic except to the extent of the sole gross negligence of any Released Party.

Responsible Party shall be liable for any loss, damage, destruction or theft to real or personal property caused by negligence or willful acts of Client. Property damage may include harm to vehicles, furnishings, fixtures or any other possession of Mind Therapy Clinic. The amount of recovery for property damage may be established by evidence of replacement value, cost of repairs, or loss of use until repaired or replaced.

The terms and conditions of this Agreement shall be jointly and severally binding upon Guarantor, Client, and their respective assigns, successors in interest, heirs, devisees and personal representatives. This Agreement shall inure to the benefit of the parties and their respective successors and assigns.

If any term or provision of this Agreement is determined to be invalid, illegal or unenforceable, the performance of the offending term or provision shall be excused as if it had never been incorporated into this Agreement, and the remaining part of this Agreement shall not be affected thereby and shall continue in full force and effect, and this Agreement shall be reformed to implement as nearly as practicable the intent hereof.

GUARANTOR, CLIENT AND MIND THERAPY CLINIC EACH EXPRESSLY ACKNOWLEDGE AND AGREE THAT THIS AGREEMENT, INCLUDING ALL EXHIBITS ATTACHED HERETO, IS A COMPLETE STATEMENT OF THE AGREEMENT OF THE PARTIES WITH RESPECT TO THE SUBJECT MATTER HEREOF AND SUPERSEDES ANY PRIOR OR CONTEMPORANEOUS REPRESENTATIONS. *Any agreement hereafter made shall be ineffective to modify, supplement or discharge the terms of this Agreement, in whole or in part, unless such agreement is in writing and signed by the party against whom enforcement of the modification is sought.*

By signing, this Financial Responsibility Agreement, the persons whose signatures are affixed hereto acknowledge that they, and each of them, have read and fully understand the terms and conditions set forth herein. Each person signing this Agreement does so intending to create a legally binding and enforceable contract with financial and other binding terms and obligations, and in the case of Guarantor and Client, are jointly and severally binding on each of them.

CLIENT:

Name: _____ Date: _____

Signature: _____

GUARANTOR:

Name: _____ Relationship to Client: _____

Signature: _____ Date: _____

MIND THERAPY CLINIC PAYMENT AGREEMENT

I acknowledge that Mind Therapy Clinic does not accept medical insurance. Therefore I choose to contract directly with Mind Therapy Clinic for psychiatric care.

I understand that I may request a receipt of services for my psychiatric care from Mind Therapy Clinic, which I may submit for reimbursement from my insurance carrier, but I further understand that my payment to Mind Therapy Clinic is not dependent upon my receiving reimbursement from my insurance carrier.

I understand that I must create an account with the medical office by submitting a credit card number prior to the scheduling of my next appointment. **I also understand that payment for all medical services is due at the time that they are rendered and will be charged to this credit card. I further understand that appointments that have not been cancelled in sufficient time (as per the Cancellation Policy) will be charged to this credit card.**

Visa/MC Number:		
Expiration: <small>MM/YYYY</small>	CVV Code (3 digits on back of card):	Billing Zip Code:
Name: (as it appears on the card)		
Cardholder Signature:		
Email Address:		

I hereby acknowledge that I have read, understand, and agree to this PATIENT PAYMENT AGREEMENT with Mind Therapy Clinic.	
Patient Signature:	Date:
Patient Name (print clearly)	
Guarantor Signature:	Date:
Guarantor Name: (print clearly)	

Financially responsible party must either provide a credit card to keep on file OR pay at the time of the visit. I, financially responsible party, agree to keep the credit card information current. I authorize Mind Therapy Clinic to securely store my credit card information, and charge it should I have an outstanding balance in the future. I understand that I may be given a receipt of services at my request, and that I may submit for reimbursement from my insurance carrier but that reimbursement is not guaranteed by Mind Therapy Clinic nor is my responsibility to pay for services dependent upon insurance reimbursement.

REGISTRATION FORM

Today's date:			Primary Care Clinician:		
PATIENT INFORMATION					
Patient's last name:		First name:	Middle:	Marital status:	
				Single / Mar / Div / Sep / Wid / Partner	
Email address:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other		DOB:	Age:
Street address:			Mobile phone #:		Home phone #:
Address to send statement if different:		City:		State:	ZIP Code:
Occupation:		Employer:			Employer phone #:
Chose clinic because/Referred to clinic by (please check one box):			<input type="checkbox"/> Dr. _____	<input type="checkbox"/> Insurance	<input type="checkbox"/> Treatment Facility
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Website		
Other family members seen here:					

INSURANCE INFORMATION					
(FOR USE IN MEDICATION AND TREATMENT AUTHORIZATIONS)					
Please give your insurance card to the receptionist if you are using your insurance for TMS treatments.					
Person responsible for bill:		Birth date: / /	Address (if different):		Phone #.:
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No		Email Address:			
Occupation:		Employer:	Employer address:		Employer phone #:
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance:					
Subscriber's name:		Subscriber's SS:	Birth date: / /	Group no.:	Policy #:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Child	<input type="checkbox"/> Spouse	<input type="checkbox"/> Other
Name of secondary insurance (if applicable):		Subscriber's name:		Group #.:	Policy #:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Child	<input type="checkbox"/> Spouse	<input type="checkbox"/> Other

PRIMARY CARE PHYSICIAN AND OTHER DOCTORS

Primary MD Name:		Clinic Name:	
Street address:		City and State:	Zip Code:
Office Phone #:		Office Fax #:	

I, _____, authorize Mind Therapy Clinic to communicate with my Primary Physician (if applicable) regarding my care. _____ (Initial)

THERAPIST AND PHARMACY

Therapist Name (If Applicable):				
Street address:	City and State:	ZIP Code:	Office Phone #:	Office Fax #:
Other MD Name (if applicable):		Other MD Contact Information:		

I, _____, authorize Mind Therapy Clinic to communicate with my Therapist (if applicable) regarding my care. _____ (Initial)

Pharmacy (REQUIRED):

Street address:		Office Phone #:	Office Fax #:
City:	State:	ZIP Code:	

CONTACTS - IN CASE OF EMERGENCY (BOTH PARENTS MUST BE LISTED FOR MINORS)

Emergency Contact:	Relationship to patient:	Home phone #:	Work phone #:
For minors, names and contact information of parents/guardians:			

The above information is true and complete to the best of my knowledge. In the event Mind Therapy Clinic submits claims on my behalf to my healthcare insurance provider, I authorize my insurance benefits to be paid directly to Mind Therapy Clinic. I understand that I am financially responsible for any balance that is not paid by my insurance and that Mind Therapy Clinic cannot guarantee the extent to which my care will be paid by insurance. I also authorize Mind Therapy Clinic or insurance company to release any information required to process my claims.

Patient/Guardian Signature	Date
----------------------------	------

PATIENT'S RIGHTS

You have the right to:

- Request and receive information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.
- Have written information about fees, method of payment, number of sessions, emergency policies, and cancellation policies before beginning therapy.
- Receive respectful treatment that will be helpful to you.
- A safe environment, free from sexual, physical and emotional abuse.
- Ask questions about your therapy.
- Refuse to answer any question or disclose any information you choose not to reveal.
- Request and receive information from the therapist about your progress.
- Know the limits of confidentiality and the circumstances in which a therapist is legally permitted or required to disclose information to others. For more information on how Mind Therapy Clinic may use and disclose your health information, please see our Notice of Privacy Practices.
- Know if there are supervisors, consultants, students or others with whom your therapist will discuss your case.
- Refuse a particular type of treatment, or end treatment without obligation or harassment.
- Refuse electronic recording (but you may request it if you wish).
- Request and (in most cases) receive a summary of your file, including the diagnosis, your progress, and the type of treatment. For more information on your rights regarding your health information, please see our Notice of Privacy Practices.
- Report unethical and illegal behavior by a therapist.
- Receive a second opinion about your therapy or therapist's methods.

If you wish to file a complaint about the clinic, you may prepare a written complaint and place it in the suggestion box in the group therapy room. This information is confidential and will only be viewed by the clinic supervisor.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES

HOW MEDICAL AND SUBSTANCE USE RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

ABOUT THIS NOTICE

Mind Therapy Clinic is required by law to maintain the privacy of your health information, to provide you with a notice of its legal duties and privacy practices, and to follow the information practices that are described in this notice. This notice explains how your health information may be used and disclosed and your rights related to your health information. You have a right to request and receive a paper copy of this notice.

Information regarding your health care, including payment of your health care, is protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. § 1320s et seq., and 45 C.F.R. Parts 160 & 164. If you receive substance use treatment from Mind Therapy Clinic, your information related to these services, including whether or not you receive these services, is also protected under the Confidentiality Law, 42 C.F.R. Part 2 ("Part 2"). Mind Therapy Clinic may not use or disclose your health information except as described in this notice and as permitted under the law.

This notice applies to health information about you that is obtained by or on behalf of Mind Therapy Clinic. Health information is information that relates to your past, present, or future physical or mental health or condition, the provision of health care products and services to you or payment for such services. We will notify you of any breach involving your health information in accordance with applicable law.

HOW WE MAY DISCLOSE YOUR HEALTH INFORMATION

As permitted by law, your treatment provider is permitted to and may choose to use or disclose protected health information (information regarding your treatment at the Mind Therapy Clinic or other relevant information that may identify you) ("PHI") without your authorization for the purposes described in this notice.

When it is important to do so, we will only use or disclose the minimum necessary PHI to the extent a recipient needs to know the information. By law, mental health professionals shall safeguard the confidential information obtained in the course of practice, research, teaching or any other professional duties. Except for the purposes set forth below, the mental health professional may only disclose your PHI to others with your written consent.

Please note that the ethical standards of mental health professionals are, in many cases, more stringent than federal and state regulations and restrict us from unnecessarily disseminating information about you. We will only do so as necessary, and will use caution with any information pertaining to you or your health status.

EXAMPLES OF HOW WE MAY USE AND DISCLOSE PHI (EXCEPT ANY INFORMATION RELATED TO SUBSTANCE USE TREATMENT YOU RECEIVE AT MIND THERAPY CLINIC)

The following section describes how Mind Therapy Clinic may use and disclose your PHI, other than information relating to any substance use treatment you may receive at Mind Therapy Clinic (for how such information may be used and disclosed, please see “Examples of How We May Use and Disclose Your Health Information that Relates to Substance Use Treatment Received at Mind Therapy Clinic”, below).

Examples of Disclosure for Treatment, Payment, and Health Care Operations

- **Treatment.** We may use PHI about you to provide you with medical treatment or services. We may disclose PHI about you to doctors, nurses, technicians, office staff, or other personnel who are involved in your care or health care decisions. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- **Payment.** We may use and disclose PHI about you so that the treatment and services we provide to you may be billed to and payment may be collected from you, an insurance company or a third party.
- **Health care operations.** We may use and disclose PHI about you in order to run Mind Therapy Clinic and make sure that you and our other clients receive quality care. For example, we may use your information to conduct cost-management and patient-care planning activities for Mind Therapy Clinic.

Examples of Other Uses and Disclosures

We also may use and disclose your PHI without your prior authorization for the following purposes:

- To Business Associates of ours, with whom we contract for services. Examples of Business Associates include consultants, accountants, lawyers, and third-party billing companies. We require these Business Associates to agree to protect the confidentiality of your PHI.
- To health oversight agencies or authorities for health oversight activities, such as auditing and licensing.
- For public health purposes, including reports to public health agencies or legal authorities charged with preventing or controlling disease, injury, or disability and reports to employers for work-related illness or injuries for workplace safety purposes
- To law enforcement authorities for law enforcement purposes as required or permitted by law for example, in response to a subpoena or court order, in response to a request from law enforcement, and to report limited information in certain circumstances.
- For judicial and administrative proceedings, including if you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may

also disclose your PHI in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to first tell you about the request or to obtain an order protecting the information requested.

- As Required by Law. We will disclose your PHI when required to do so by federal, state or local law.
- To make reports on abuse, neglect, or domestic violence to a government authority if we reasonably believe you are a victim of abuse or neglect. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else.
- To avert a serious threat to public health or safety, or to prevent serious harm to an individual.
- To Coroners and medical examiners and funeral directors, as necessary, to carry out their duties.
- To organizations for purposes of disaster relief efforts.
- For research projects that are subject to a special approval process. We may use your health information to conduct research and we may disclose your PHI to researchers as authorized by law. For example, we may use or disclose your PHI as part of a research study when the research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information..
- For specialized government functions; for example, as required by military authorities or to federal officials for intelligence, counterintelligence, protection of the President, and other national security activities authorized by law.
- To correctional Institutions if you are or become an inmate of a correctional institution, for your health and the health and safety of other individuals.
- For workers compensation purposes as necessary to comply with worker's compensation or other similar programs established by law.
- Incidental Disclosures. While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during, or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

In other instances, we may use or disclose PHI without written authorization but provide you with an opportunity to agree or object to the use or disclosure. This will occur when a use or disclosure to a family member, relative or close personal friend, or any other individual you identify, is important to provide these individuals with information regarding your health care, payment, location, general condition or death, or to assist in disaster relief efforts. In

emergency circumstances, we may not be able to obtain your agreement or objection; in these cases we will use our professional judgment to act in your best interests.

EXAMPLES OF HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION THAT RELATES TO SUBSTANCE USE TREATMENT RECEIVED AT MIND THERAPY CLINIC

The following section describes how Mind Therapy Clinic may use and disclose your health information that relates to substance use treatment received at our clinic. Under federal regulations referred to as Part 2, more stringent confidentiality and privacy protections apply to your health information that identifies you as a substance use treatment patient ("Part 2 Information"). We may not disclose to a person outside of Mind Therapy Clinic that you received substance use treatment at our clinic, nor may Mind Therapy Clinic disclose any Part 2 Information, except as permitted by federal law.

Mind Therapy Clinic must obtain your written consent before it may disclose Part 2 Information for payment purposes. Generally, you must also sign a written consent before Mind Therapy Clinic can share Part 2 Information for treatment or for health care operations.

Examples of Disclosures Of Part 2 Information

Under federal law, we may use and disclose Part 2 Information without your prior consent for the following purposes:

- Pursuant to an agreement with a qualified service organization/business associate, with whom we contract for services;
- For research, audit, or evaluations;
- To report a crime committed on Mind Therapy Clinic's premises or against Mind Therapy Clinic's personnel;
- To medical personnel in a medical emergency;
- To appropriate authorities to report suspected child abuse or neglect; and
- As allowed by court order.

OTHER USES AND DISCLOSURES

Your written authorization is required to disclose psychotherapy notes, except in cases in which we must use such information to defend ourselves in legal action/proceedings involving you.

Before Mind Therapy Clinic may use or disclose any information about your health in a manner not described in this Notice, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by your orally or in writing. Upon receipt of the

written revocation, we will stop using or disclosing your health information, except to the extent that we have already taken action in reliance on the authorization.

YOUR RIGHTS

You have individual rights over the use and disclosure of your PHI, including the rights listed below. You may exercise any of these rights by submitting your request in writing. Please contact the Office Manager to obtain the applicable request form. We will evaluate each request and communicate to you whether or not we can honor the request. We may also charge a reasonable fee for costs associated with your request to the extent permitted by law. We will notify in advance of the cost, and you may withdraw your request before you incur any cost.

Restrict use

You may request, in writing, restrictions on certain uses and disclosures of your information. We will consider but are not legally required to accept most requests. After review of your request, we will notify you of our determination in writing. We must accept your request only if the restricted disclosure is to a health plan for the purpose of carrying out payment or health care operations, disclosure of such information is not required by law, and the restricted information pertains to an item or service for which you paid in full out-of-pocket.

Upon request, you may receive confidential communications by alternative means or at alternative locations. This includes an alternative mailing address or telephone number.

Inspect and copy

With a few exceptions, you have the right to access and obtain a copy of the health information that we maintain about you. If we maintain an electronic health record containing your health information, you have the right to obtain the health information in an electronic format. You may ask us to send a copy of your health information to other individuals or entities that you designate. We may deny your request to inspect and copy in certain circumstances. If you are denied access to your health information, you may request that the denial be reviewed in some cases.

Request corrections

You have the right to request in writing that we correct information in your record that you believe is incorrect or add information that you believe is missing.

Know about disclosures

You have the right to an accounting of instances where we have disclosed your health information for certain purposes other than for treatment, payment, health care operations, or other exceptions. Your request must be made in writing and may be for disclosures made up to 6 years before the date of your request.

File complaints

If you are concerned that we have violated your privacy or disagree with a decision we made about access to your record, you may file a complaint about the clinic and submit it to our HIPAA Officer

You also may file a written complaint to the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized nor retaliated against if you file a complaint.

CHANGES TO THIS NOTICE

This notice is effective as of **March 1, 2019**. We may change the terms of our notice at any time. The new notice will be effective for the health information that we maintain. The revised notice will be posted at our places of service. You may request a copy of the current notice at any time by contacting our HIPAA Officer at 415-945-9870.

Acknowledgment

I/We, _____, acknowledge receiving and reading a copy of the above information, and have had the opportunity to ask whatever questions necessary for clarification.

Client _____ Date _____

If no signature is obtained, document efforts to obtain signature and reasons why the document was not signed:

HOURS OF OPERATION

Mind Therapy Clinic's clinical/business hours are **Monday-Friday 9:00 am to 6:00 pm**
 For situations arising after hours and on weekends:

Marin	San Francisco
Call 911 for emergencies.	
Call Marin Crisis Center, 415 473-6666 ext 24 , for psychiatric emergency services including urgent consultation.	Call SF Crisis Hotline (415) 781-0500 or 800 /273-8255
Visit the Marin Psychiatric Emergency Room on the Marin General Hospital campus at 250 Bon Air Rd in Greenbrae.	Crisis Text Line 24/7 Confidential Support: text MYLIFE to 741741
Leave a message for the primary therapist, physician or family therapist in the event you have sought help from any of the above.	Visit the SF Psychiatric Emergency Services on the SF General Hospital campus at 1001 Potrero Ave., San Francisco 94110. Phone number: 415-206-8125
<i>For non-emergencies:</i> Leave a message for the primary therapist, physician or family therapist who will generally respond within one business day.	Leave a message for the primary therapist, physician or family therapist in the event you have sought help from any of the above
	<i>For non-emergencies:</i> Leave a message for the primary therapist, physician or family therapist who will generally respond within one business day.

Medication refills are provided during regular business hours. Please request medication refills directly from your pharmacy, allowing at least **five (5)** business days before running out. Have your pharmacy send refill requests electronically or by fax to: **415 945-9325**. For refills or prescription problems contact **415 945-9870**. *Note - most pharmacies will provide a one or **two (2)** day emergency supply of most medications.

PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION FOR PRIOR AUTHORIZATION OF MEDICATION

I authorize Mark Schiller, M.D. and Mind Therapy Clinic to submit my patient information to CoverMyMeds for the purpose of assisting in managing the prior authorization or other coverage determination process for prescription drugs. This information may include but is not limited to my name, date of birth, address and contact information, my medical condition, my treatment history, including prescription medications, my health insurance information, and/or financial information. This information is considered Protected Health Information (“PHI”), and is subject to local, state and federal regulations, and the HIPAA Privacy Rule, located at [45 CFR Part 160](#) and [Subparts A and E of Part 164](#).

Once my PHI is submitted to CoverMyMeds, I understand that it will be used to submit coverage determinations to my health plan, and may be shared with related physician or pharmacy staff involved in my care. I understand that my information will be used only to the extent necessary to submit coverage determinations, and will not be published to those not involved in my care. However, I acknowledge that once my PHI is disclosed to third parties, it may no longer be subject to protection under the HIPAA Privacy Rule. I can review the full privacy policy at:

http://www.covermymeds.com/main/privacy_policy or by writing to: Privacy Office, CoverMyMeds LL, 2 Miranova Pl., Floor 12, Columbus, Ohio 43215 or emailing to privacy@covermymeds.com

This authorization will be effective until I notify my provider that I do not want my information to be disclosed to CoverMyMeds. I understand that I can revoke this authorization at any time, that I am not required to sign this form, and that my healthcare provider cannot condition treatment or eligibility for benefits on my execution of this authorization. I understand that I have a right to receive a copy of this form.

NAME	
SIGNATURE	
DATE	
CAREGIVER	<i>relationship to patient and your signing rights on behalf of patient here.</i>

This authorization form does not form a relationship between the patient and CoverMyMeds or its customers. This form may be modified for use by healthcare providers who wish to supplement their existing consent program to ask for specific patient approval to use the CoverMyMeds service in the course of patient care. Providers should ensure that their consent program meets all applicable local, state, and federal regulations.

ADULT INTAKE EVALUATION

Name:	Date of Birth:	Age:	Gender:
Others Present:			
Marital Status: <i>Married/Divorced/Separated/Single/In Relationship</i>		How long have you been with your partner/married?	
Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, indicate how many and their ages. How many: Ages:	
Current living situation (relationship of person(s) with whom patient resides)?			
Allergies to medication: <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, please describe:	

REASON FOR THIS APPOINTMENT

What are the reasons you scheduled an appointment?		
How long have you had these symptoms?		
Are these symptoms related to a life situation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, please explain:		
Do these symptoms seem to come and go regularly, as in a cycle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, please describe:		

Are you currently in psychotherapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, who is your therapist and how long have you seen him/her?		
Do you feel that your current or past psychiatric care/psychotherapy has been helpful to you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Why or why not?		

SYMPTOMS

Do you <u>currently</u> , or have you in the past, experienced: (check all that apply)		
<input type="checkbox"/> Depressed mood	<input type="checkbox"/> Unable to enjoy activities	<input type="checkbox"/> Sleep pattern disturbance <input type="checkbox"/>
<input type="checkbox"/> Loss of interest	<input type="checkbox"/> Concentration issues/forgetfulness	<input type="checkbox"/> Change in appetite <input type="checkbox"/>
<input type="checkbox"/> Excessive guilt	<input type="checkbox"/> Feeling worthless	<input type="checkbox"/> Fatigue <input type="checkbox"/>
<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Restlessness	<input type="checkbox"/> Feeling Slowed down
<input type="checkbox"/> Racing thoughts <input type="checkbox"/>	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Increase risky behavior
<input type="checkbox"/> Increased libido <input type="checkbox"/>	<input type="checkbox"/> Decreased need for sleep	<input type="checkbox"/> Excessive energy
<input type="checkbox"/> Increased irritability	<input type="checkbox"/> Crying spells	<input type="checkbox"/> Excessive worry
<input type="checkbox"/> Anxiety/Panic attacks	<input type="checkbox"/> Avoidance	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Suspiciousness <input type="checkbox"/>	<input type="checkbox"/> Feeling hopeless	<input type="checkbox"/> Enter OTHER symptoms

Have you ever had <u>feelings or thoughts that you did not want to live</u> ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No (Skip to next section)
If YES, please answer the following questions.		
Do you <u>currently</u> feel that you do not want to live?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, how often do you have these thoughts?		

When was the last time you had thoughts of dying?		
If YES, has anything happened recently to make you feel this way?		
On a scale of 1 to 10 (10 being strongest), how strong is your desire to kill yourself currently?		
Would anything make it better?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, please explain:		
Have you ever thought about how you would kill yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, please explain:		
Is the method you would use readily available?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you planned a time for this?		
Is there anything that would stop you from killing yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, please explain:		
Have you ever tried to kill or harm yourself before?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, please explain:		
Do you <u>currently</u> engage in cutting, burning or other self-harm?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, please explain:		
Have you had one or more <u>severely stressful events</u> that have affected your well-being?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If YES, please explain

MEDICAL

Medications:

IMPORTANT: Please list any prescription & nonprescription medications, vitamins, supplements or herbs; include name, dose & how often taken and see appendix for list of medications.

List all current medication name(s):

List the dosage and how often taken for each medication listed above:

List all past medication(s):

Why did you discontinue taking each medication listed above:

Who has been prescribing your medications (please include the name and location of the prescriber)?

Are any of your relatives on medications?

Yes No

If YES, please list the medications.

Were they helpful?

Do you have any of the following medical conditions? (check all that apply):

High/Low blood pressure

High cholesterol

Heart disease

Cancer

Diabetes

Liver problems

Kidney problems

Respiratory problems

Asthma

<input type="checkbox"/> Nervous system disorder	<input type="checkbox"/> Seizures	<input type="checkbox"/> Gastrointestinal problems
<input type="checkbox"/> Blood disorder	<input type="checkbox"/> Thyroid disorder	<input type="checkbox"/> Other glandular disorder
<input type="checkbox"/> Sleep disorder	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Pain disorder
<input type="checkbox"/> Other (please be specific):		

When was your most recent <u>physical</u> ?	MM/DD/YYYY	
Did you or your doctor have any concerns about your health?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, please describe:		
Did you have any blood work done (i.e., thyroid testing)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, was anything abnormal?		

Check any significant <u>family medical illness or history</u> :		
<input type="checkbox"/> High/Low blood pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Thyroid disorder
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Sleep disorder	<input type="checkbox"/> Other glandular disorder
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Seizures	<input type="checkbox"/> Nervous system disorder
<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Pain disorder	<input type="checkbox"/> Headaches/Migraines
<input type="checkbox"/> Respiratory problems	<input type="checkbox"/> Blood disorder	<input type="checkbox"/> Gastrointestinal problems
<input type="checkbox"/> Glucose intolerance and/or diabetes	<input type="checkbox"/> Other:	

How is your <u>appetite</u> ?		
Have you had any recent changes in weight?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, please describe:		
Do you suffer from anorexia, bulimia or any other eating disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If YES, please describe:

How are you functioning sexually?

Are any of your medications causing sexual side effects?

Yes

No

If YES, please describe the side effects.

Are there other medical symptoms we should know about (e.g. forgetfulness, weight changes, dry or coarse skin/hair, change in bowel habits, etc.)?

SLEEP HABITS

Do you have any trouble falling asleep?

Yes

No

If YES, what prevents you from falling asleep?

How is the quality of your sleep (e.g., light, deep, etc.)?

Do you snore?

Yes

No

Don't Know

Have you been told that you stop breathing or gasp for breath when asleep?

Yes

No

Don't Know

Do you wake up in the middle of the night?

Yes

No

If so, how often and are you able to fall back to sleep?

Yes

No

Sometimes

Do you feel rested in the morning?

Yes

No

Sometimes

How long have you suffered with sleep problems?

SUBSTANCE ABUSE

Do you use alcohol? Yes No

If YES, how many drinks per night, and how many nights per week do you drink?

When you drink do you drink to get buzzed, drunk or black-out?

Do you use nicotine? Yes No

If YES, how much/often?

Do you drink caffeinated drinks? Yes No

If YES, what and how much/often?

Do you use any recreational drugs? Yes No

If YES, please fill out this section. If NO, please skip substance use section.

Substance of Choice	How much?	Age of first use	Last use	Reason and Consequence
Tobacco				
Alcohol				
Marijuana or K2/"spice"				
Cocaine				
Opiates (e.g. Heroin, Kratom, Morphine, Percocet, Oxycodone, Tylenol #3, Dilaudid/hydromorphone)				

Tranquilizers/sedatives (e.g. Xanax, Ativan, Klonopin, Valium)				
PCP or LSD				
Mushrooms				
Other:				

Does your use of any of alcohol or these substances play a part in the reason for your appointment today?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, please explain:		
Do your family or friends voice concern?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been treated for alcohol or substance abuse in the past?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, when and what type of treatment did you receive?		
Do any genetic relatives have a history of problems with alcohol or substance abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, which relative(s)?		

PSYCHIATRIC HISTORY		
Have you had any past psychiatric treatment or psychotherapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, please list the names of the psychiatrists or therapists you have seen, why you were you seen, when and for how long you were treated:		
<u>Current and Past Diagnoses:</u>		
<input type="checkbox"/> Anxiety	<input type="checkbox"/> ADHD	<input type="checkbox"/> Bipolar Disorder <input type="checkbox"/>
<input type="checkbox"/> Depression	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> OCD	<input type="checkbox"/> Trauma-related Disorder	<input type="checkbox"/> Somatic Symptom Disorder

<input type="checkbox"/> Autism Spectrum Disorder	<input type="checkbox"/> Alcohol/ Substance Abuse Disorders	<input type="checkbox"/> Personality Disorders
<input type="checkbox"/> Learning Disorders: <input type="checkbox"/>	<input type="checkbox"/> Other:	
Have you had any hospitalizations for a psychiatric condition?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain (reason, length, etc.):		
Where and when were you hospitalized?		
Is there any <u>psychiatric history in your family</u> ?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, please explain:		
Have you ever <u>attempted suicide</u> ?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, please explain (circumstance, lethality, means, plan, medical attention needed):		
Is there a <u>family history</u> of suicide attempts and/or completed suicide?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, explain:		
Have you ever engaged in cutting, burning or other self-mutilation?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, please explain:		

MEDICAL HISTORY			
<u>Head Injuries:</u>			
Have you ever had any head injury, sports injury to the head, falls, concussions or car accidents?		<input type="checkbox"/> Yes	<input type="checkbox"/> No (Skip to the next section)
If YES, please describe where on the head the injury occurred and at what age:			
Did you experience amnesia or lose consciousness after the injury?		<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't Know

Has there been any change in mood or memory since the head trauma occurred?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If YES, please describe the change in mood or memory.			
Were you hospitalized for the head injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If YES, please provide details of the hospitalization.			
Was any type of scan performed (CAT, MRI, EEG, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
If YES, what did it show?			
<u>Pain:</u>			
Do you have any problems with pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No (Skip to the next section)	
If YES, please describe:			
What is your average daily pain level, using the pain scale from 1 to 10, 10 being excruciating pain?			
How long have you been suffering with this level of pain?			
Are you being treated for this problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If YES, by whom?			
<u>Female Patients:</u>			
Do you have regular periods?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
If NO, please describe:			
Are you taking contraceptives?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

If YES, did you notice a change in your mood when you started or stopped birth control?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If YES, please describe:			
Have you noticed any perimenopausal/menopausal symptoms (i.e., hair falling out, dry eyes, irregular periods, irritability, vaginal dryness, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
If YES, have you consulted a doctor about this?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Did the doctor do any additional tests other than blood work, or how did the doctor treat your condition?			
Do you experience any PMS symptoms?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If YES, please describe:			

CHILDHOOD/CULTURAL HISTORY

Please describe your childhood, including your parents' relationship, lifestyle, siblings and their ages, relationships, friendships, environment, any trauma, physical, emotional or sexual abuse, and birth history.

Are there any cultural or spiritual factors that you would like to tell us about?

Support System:

Do you feel that you have a support system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, check all that apply:	<input type="checkbox"/> Family	<input type="checkbox"/> Coworkers <input type="checkbox"/> Friends
	<input type="checkbox"/> Significant other	<input type="checkbox"/> Others

ACADEMIC/VOCATIONAL HISTORY

Please describe your educational and vocational history:

MILITARY		
Have you ever served in the <u>military</u> ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, what branch of the military?		
What type of discharge did you receive?		

LEGAL HISTORY		
Have you ever had any legal problems including jail, prison, lawsuits, bankruptcy, DUI etc.?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, please explain		

Are you presently on diversion or probation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, what are the requirements of your diversion or probation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No