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# **INFORMATION, AUTHORIZATION, &**

# **CONSENT TO PSYCHOSOCIAL EVALUATION**

 Welcome to **ALAN BEHRMAN & ASSOCIATES**. We are very pleased that you selected our facility for your psychosocial evaluation, and we are sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from your therapist, policies regarding confidentiality and emergencies, and several other details regarding your psychosocial evaluation here at **ALAN BEHRMAN & ASSOCIATES**. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you to keep you fully informed of every part of your experience. Please know that your relationship with your therapist is a collaborative one, and we welcome any questions, comments, or suggestions regarding the course of your psychosocial evaluation at any time.

**Theoretical Views & Client Participation**

 In order for your psychosocial evaluation to be most successful, it is important for you to take an active role. This involves promptly submitting supplementary documents to your therapist, such as a marriage certificate, police reports, personal declarations or affidavits, etc., preferably before your initial interview. These documents are crucial as they substantiate the information you provide, enhancing the credibility of your report. Before your first appointment, you will receive a detailed list of the specific documents required, based on the type of immigration benefit you are seeking.

Your active participation is key during your interviews with your therapist. Unlike other evaluations that aim to demonstrate mental stability, an immigration psychosocial evaluation serves a different purpose. Its objective is to assess your mental health considering any extreme hardship or trauma you have experienced, and to determine if additional emotional harm, trauma, or extreme hardship would occur if you, your spouse, or a relative were required to leave (or were not permitted to return) to the United States. Please avoid any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your interview sessions.

 As a client, you are in complete control, and you may end your relationship with your therapist at any time. Please note that you will be charged the appropriate fees in order to fairly compensate the therapist for their time and labor already invested in your evaluation, even if you choose to withdraw from the process. We encourage you to let us know if you feel that transferring to another practice or another therapist is necessary at any time. Our goal is to support you throughout the immigration process, and we are very committed to helping you in whatever way seems to produce maximum benefit. If at any point you are unable to keep your appointments or we don't hear from you for one month, we will need to close your file. However, reopening your case and resuming the evaluation is always an option, but please be advised that additional fees may apply.

**Confidentiality & Records**

 Your communications with your therapist will become part of a clinical record, and it is referred to as Protected Health Information (PHI). Your PHI will be stored electronically with TherapyNotes, a secure storage company that has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA-compatible, secure format using point-to-point, Federally-approved encryption. Your PHI will also be kept on a password-protected computer system in an encrypted file format.

Your immigration attorney referred you for this evaluation to gather relevant information pertaining to your legal immigration case. In order to fulfill our role in assisting you with this matter, any information you provide to your therapist for the purpose of this evaluation will be shared with your attorney and their authorized representatives, including paralegals and assistants who work in the firm. To proceed accordingly, please provide your attorney, paralegal, and or firm’s name, contact details, and consent to this communication exchange between your therapist and your legal team enclosed on the “Release of Information” form. This also includes the electronic delivery of your report.

 There are a few other people who may also have access to your PHI. The practice owner, Alan Behrman, may review your case with your therapist in the interest of providing you with the best possible service and evaluation. As a licensed clinician, Alan Behrman is also required to keep all information about clients confidential. Additionally, one of our administrative assistants or our business manager may need to access your chart on occasion for business purposes only. This might be to check for dates of services, ascertain that all the HIPAA-required documentation is located in the chart (occasional audit of charts), or some other absolutely necessary business practice. However, please know this would never include reading your psychosocial evaluation or related clinical information. Additionally, each business associate has signed a HIPAA-enforced confidentiality contract, which spells out how confidential records must be handled.

For quality assurance purposes, the report of your psychosocial evaluation will be reviewed by a ghostwriter and/or your therapist’s supervisor before it is delivered to the designated party you listed on the “Release of Information” form. This review may include examining any supplemental documents you provide to corroborate dates, name spellings, and overall accuracy of the factual data in the report. In some cases, a translation agency may be contracted for services, and they will be present during your interviews to interpret sensitive and confidential information. This may also include translating written communication or documents, in some cases. Rest assured, all individuals involved are bound by strict HIPAA Business Associate Agreements (BAAs) to protect your privacy.

 Your therapist will always keep everything you say completely confidential, with the following exceptions: (1) you direct your therapist to tell someone else, and you sign a “Release of Information” form; (2) your therapist determines that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) your therapist is ordered by a judge to disclose information. In the latter case, your therapist’s license does provide them with the ability to uphold what is legally termed “privileged communication.” Privileged communication is your right as a client to have a confidential relationship with a counselor. If, for some unusual reason, a judge were to order the disclosure of your private information, this order can be appealed. We cannot guarantee that the appeal will be sustained, but we will do everything in our power to keep what you say confidential. Since I practice in more than one state, I will make sure to provide you with any additional information related to confidentiality in the state where you are at the time of services as necessary.

**Professional Relationship**

 Your relationship with your therapist has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and your therapist were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client’s interests, and then the client’s (your) interests might not be put first. In order to offer all of our clients the best care, your therapist’s judgment needs to be unselfish and purely focused on your needs. This is why your relationship with your therapist must remain professional in nature.

 There is a specific dual relationship that we are ethically required to avoid. This is providing therapy, psychotherapy, counseling, or any similar practice while also conducting a psychosocial evaluation or assessment, even after the service has concluded. These are considered mutually exclusive services, and you must hire a therapist specifically for psychotherapy or counseling, which is categorized as "treatment," and not “assessment.”

Please refer to the definitions below for the state of Georgia:

“Assessment” means the use of formal and informal techniques to identify the strengths and weaknesses of individuals, families, and groups, and to develop a plan for intervention (Official Code of Georgia Annotated (O.C.G.A.), Title 43, Chapter 10A, § 43-10A-3(1)).

“Professional counseling” means the application of mental health, psychological, and human development principles in order to facilitate human development and adjustment throughout life; prevent, diagnose, and treat mental, emotional, or behavioral disorders and associated distresses which interfere with mental health; conduct assessments for the purpose of establishing treatment goals and objectives; and plan, implement, and evaluate treatment plans using counseling treatment interventions (Official Code of Georgia Annotated (O.C.G.A.), Title 43, Chapter 10A, § 43-10A-3(10)).

Please refer to the definitions below for the state of North Carolina:

“Assessment” means selecting, administering, scoring, and interpreting instruments designed to assess and individual’s aptitudes, attitudes, abilities, achievements, interests, and personal characteristics, but shall not include the use of projective techniques in the assessment of personality (North Carolina General Assembly, Chapter 90, Article 24, § 90-330(a)(2)).

“Counseling” means assisting individuals or groups, through the counseling relationship, to develop an understanding of personal problems, to define goals, and to plan action reflecting interests, abilities, aptitudes, and needs as these are related to personal-social concerns, educational progress, and occupations and careers (North Carolina General Assembly, Chapter 90, Article 24, § 90-330(a)(3)).

If you are being evaluated in a state other than Georgia or North Carolina, please refer to your state’s definitions of “Assessment” vs “Counseling.”

Our passion is providing you with the best psychosocial evaluation possible. Therefore, by signing this document, you acknowledge that your therapist will be providing a psychosocial evaluation specifically for your immigration case, and not therapy, psychotherapy, counseling, treatment, or other similar service. You also understand that this means your therapist will not participate in any other forensic activities, including but not limited to custody evaluations, depositions, or court proceedings. However, if for some reason we are compelled to testify to a court of law, we will require an upfront retainer of $3,000.00, and our billing rate will be $500.00 per hour*,* plus you agree to be responsible for the reasonable attorney fees we are charged by our counsel. Additionally, if we receive a valid subpoena or court order to produce documents that we cannot prevent, we will need to charge you reasonable and customary fees based on state and Federal guidelines of $1.00 per page (or the maximum allowed by law) to produce those records. If a summary of your report is accepted instead of the entire set of records, we charge the prorated hourly rate of your therapist for the time to produce this summary. We will also need to charge you the reasonable attorney fees associated with that production, which will take place by and through my counsel’s office to preserve your confidentiality.

 Additionally, since therapists are required to keep the identity of their clients confidential, as much as your therapist would like to, for your confidentiality, they will not address you in public unless you speak to them first. Your therapist also must decline any invitation to attend gatherings with your family or friends. Lastly, when your psychosocial evaluation is completed, your therapist will not be able to be a friend to you like your other friends. In sum, it is the duty of your therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way; they are strictly for your long-term protection.

**Statement Regarding Ethics, Client Welfare & Safety**

**ALAN BEHRMAN & ASSOCIATES** assures you that our services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association. If at any time you feel that your therapist is not performing in an ethical or professional manner, we ask that you please let your therapist know immediately. If the two of you are unable to resolve your concern, we will provide you with information to contact the professional licensing board that governs the therapist’s profession.

Due to the very nature of immigration evaluations, as much as we would like to guarantee specific results regarding your case, we are unable to do so. Additionally, we are not able to provide any legal advice. However, your therapist, with your participation, will work to achieve the best possible psychosocial evaluation for you.

Please also be aware that, at times, people find that they feel somewhat worse during and after undergoing the evaluation process. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn’t sensitive unless it needs attention. Therefore, it is highly recommended that you follow up with some form of mental health treatment. Once you and your therapist determine your specific needs, they will be able to provide appropriate referrals for therapy or counseling, psychiatric treatment, and/or other relevant resources.

For the safety of all our clients, their accompanying family members and children, and our therapists and staff, **ALAN BEHRMAN & ASSOCIATES** maintains a zero-tolerance weapons policy. No weapon of any kind is permitted on the premises, including guns, explosives, ammunition, knives, swords, razor blades, pepper spray, garrotes, or anything that could be harmful to yourself or others. **ALAN BEHRMAN & ASSOCIATES** reserves the right to contact law enforcement officials and/or terminate treatment with any client who violates our weapons policy.

**Telemental Health Statement**

 In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to us that we maintain your confidentiality, respect your boundaries, and ascertain that your relationship with your therapist remains professional.

Telemental Health is defined as follows:

 “Telemental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. Telemental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers.” (Georgia Code 135-11-.01)

North Carolina recognizes the delivery of mental health services via telehealth, though it may not use the specific term “Telemental Health.” Telehealth services in North Carolina are regulated by the state’s licensing boards and may require adherence to specific standards of practice, including informed consent, documentation, and security.

Telemental Health is a relatively new concept despite the fact that many therapists have been using technology-assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of Telemental Health services in order to provide you with the highest level of service. Therefore, our therapists have completed specialized training in Telemental Health. We have also developed several policies and protective measures to ensure your PHI remains confidential. These are discussed below.

**The Different Forms of Technology-Assisted Media Explained**

**Telephone via Landline:**

 It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special technology. Individuals who have access to your telephone or your telephone bill may be able to determine who you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided us with that phone number, we may contact you on this line from our own landline in our office or from a cell phone, typically only for the purpose of setting up an appointment if needed. If this is not an acceptable way to contact you, please let your therapist know.

**Cell phones:**

 In addition to landlines, cell phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see who you have talked to, who initiated that call, how long the conversation was, and where each party was located when that call occurred. However, we realize that most people have and utilize a cell phone. We may also use a cell phone to contact you, typically only for the purpose of setting up an appointment if needed. Additionally, your therapist may keep your phone number in their cell phone, but it will be listed by your initials only without descriptors. If this is a problem, please let your therapist know, and your therapist will be glad to discuss other options.

**Text Messaging:**

 Text messaging is not a secure means of communication and may compromise your confidentiality. Furthermore, sometimes people misinterpret the meaning of a text message and/or the emotion behind it. Therefore, we do not utilize texting in this therapy practice, and we will not respond to a text message for your protection. If you happen to send me a text message by accident, you need to know that we are required to keep a copy or summary of all texts as part of your clinical record that address anything related to the evaluation.

**Email:**

 We utilize a secure email platform that is hosted by Hushmail. We have chosen this technology because it is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that the company is willing to attest to HIPAA compliance and assume responsibility for keeping your PHI secure. If we choose to utilize email as part of your psychosocial evaluation, we encourage you to also utilize this kind of software for protection on your end. Otherwise, when you reply to one of your therapist's emails, everything you write in addition to what your therapist has written to you (unless you remove it) will no longer be secure. Our encrypted email service only works to send information and does not govern what happens on your end.

 We also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall and anti-virus software installed, is password protected, does not access the Internet through a public wireless network, etc.). If you are in a crisis, please do not communicate this to us via email because we may not see it in a timely matter. Instead, please see below under "Emergency Procedures."

 If you are in a crisis, please do not communicate this to us via email because we may not see it in a timely matter. Instead, please see below under "Emergency Procedures." Finally, you also need to know that we are required to keep a copy or summary of all emails as part of your recordthat addresses anything related to your psychosocial evaluation.

**Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc.:**

 It is our policy not to accept "friend" or "connection" requests from any current or former client on any of our therapist's **personal** social networking sites, such as Facebook, Twitter, Instagram, Pinterest, etc., because it may compromise your confidentiality and blur the boundaries of your relationship.

**Video Conferencing (VC):**

 Video Conferencing is an option for your therapist to conduct remote sessions with you over the Internet, where you may speak to one another as well as see one another on a screen. We utilize Psychology Today. This VC platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that Psychology Today is willing to attest to HIPAA compliance and assumes responsibility for keeping your VC interaction secure and confidential. If you and your therapist choose to utilize this technology, your therapist will give you detailed directions regarding how to log in securely. If either of us encounter any technological issues with Psychology Today, other VC platforms that have also signed a BAA like Zoom and Doxy.me can be used as backup. We also ask that you please sign on to the platform at least five minutes prior to your session time to ensure you and your therapist get started promptly. Additionally, you are responsible for initiating the connection with your therapist at the time of your appointment.

 We strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall and anti-virus software installed, is password protected, does not access the Internet through a public wireless network or can turn on a virtual private network, etc.).

**Recommendations for Websites or Applications (Apps):**

 During the course of the psychosocial evaluation, your therapist may recommend that you visit certain websites for pertinent information or self-help. Your therapist may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites and/or apps may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide if you would like this information as an adjunct to your psychosocial evaluation or if you prefer that your therapist does not make these recommendations. Please let your therapist know by checking (or not checking) the appropriate box at the end of this document.

**Electronic Record Storage:**

 Your communications with us will become part of a clinical record, and it is referred to as Protected Health Information (PHI). Your PHI will be stored electronically with TherapyNotes, a secure storage company that has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA-compatible secure format using point-to-point, Federally-approved encryption**.** Your PHI will also be kept on a password-protected computer in an encrypted file format.

**Electronic Transfer of PHI for Certain Credit Card Transactions:**

 Your PHI will be securely transferred electronically to TherapyNotes. This billing company has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, federally approved encryption. Additionally, if your insurance provider is billed, you will generally receive correspondence from your insurance company, my billing company, or both.

**Your Responsibilities for Confidentiality & Telemental Health**

 Please communicate only through devices that you know are secure, as described above. It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any Telemental Health sessions.

**In Case of Technology Failure**

 During a Telemental Health session, you and your therapist could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Please make sure you have a phone with you and your therapist has that phone number. Your therapist may also suggest utilizing other videoconference options as backup if preferred.

 If you and your therapist get disconnected from a videoconferencing or chat session, end and restart the session. If you are unable to reconnect within ten minutes, please call your therapist.

 If you and your therapist are on a phone session and you get disconnected, please call your therapist back or contact your therapist to schedule another appointment. If the issue is due to your therapist's phone service, and the two of you are not able to reconnect, your therapist will not charge you for that session.

**Limitations of Telemental Health Services**

 Telemental Health services may have some limitations. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, your therapist might not see a tear in your eye. Or, if audio quality is lacking, your therapist might not hear the crack in your voice that your therapist could easily pick up if you were in person.

 There may also be a disruption to the service (e.g., the phone gets cut off or the video drops). This can be frustrating and interrupt the normal flow of personal interaction.

 Please know that your therapist has the utmost respect and positive regard for you and your well-being. Your therapist would never do or say anything intentionally to hurt you, and we strongly encourage you to let your therapist know if something they have done or said has upset you. We invite you to keep communication open with your therapist at all times to reduce any possible harm.

**Identification & Passwords for New Clients**

 During your first session, your therapist will require you to show a valid picture ID and another form of identity verification, such as a credit card in your name. **At this time, you will also choose a password, phrase, or number that you will use to identify yourself in all future sessions. This procedure prevents another person from posing as you.**

**Consent to Telemental Health Services**

 Please check the Telemental Health services you are **NOT** authorizing me to utilize for your treatment or administrative purposes. Together, we will ultimately determine which modes of communication are best for you. However, you may change your mind and authorize the use of any of these services at any time during the course of your psychosocial evaluation just by notifying me in writing. If you do not see an item discussed previously in this document listed for you to opt out of, this is because it is a standard feature built-in to the majority of therapy practices, and I will be utilizing that technology unless otherwise negotiated by you (e.g., an encrypted electronic health records platform that includes a portal for communication and scheduling). Again, please **Opt-Out** of any of the following technology you would **NOT** like for me to utilize in your evaluation.

* Recommendations for Websites or Apps

In summary, technology is constantly changing, and all the above has implications that we may not realize at this time. Feel free to ask questions, and please know that we are open to any feelings or thoughts you have about these and other modalities of communication.

**Communication Response Time**

 Our practice is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry beepers nor are we available at all times. If at any time this does not feel like sufficient support, please inform your therapist, and your therapist can discuss additional resources or refer your case to a therapist or clinic with 24-hour availability. We will return phone calls and/or emails within 24 hours. However, we do not return calls and/or emails on weekends or holidays. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

**In Case of an Emergency**

GEORGIA (Atlanta and surrounding areas):

 If you have a mental health emergency, we encourage you not to wait for a return call but to do one or more of the following:

* Call Behavioral Health Link/GCAL: 800-715-4225
* Call Emory University Hospital at Wesley Woods: 404-728-6222
* Call Ridgeview Institute: 770-434-4567
* Call Peachford Hospital: 770-454-5589
* Call or text 988 Suicide Prevention & Crisis Line
* Crisis Text Line: Text “Home” to 741741
* Call 911
* Go to the emergency room of your choice

NORTH CAROLINA (triad area):

* Call Hope4NC Helpline: 1-855-587-3463
* Call Atrium Health Wake Forest Baptist MHS at Jonestown Road: 336-716-4551
* Call Novant Health Behavioral Health Center: 336-718-3550
* Call Cone Health Behavioral Health Hospital: 336-832-9700
* Call Guilford County Behavioral Health Center: 336-890-2700
* Call or text 988 Suicide Prevention & Crisis Line
* Crisis Text Line: Text “Home” to 741741
* Call 911
* Go to the emergency room of your choice

National Numbers:

* Call or Text 988 Suicide & Crisis Lifeline
* National Alliance on Mental Illness (NAMI) Helpline: 1-800-950-NAMI (6264)
* Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline: 1-800-662-HELP (4357)
* Veterans Crisis Line: Call 1-800-273-8255 and press 1, or text 838255
* Call 911
* Go to the emergency room of your choice

 If you and your therapist decide to include Telemental Health as part of your treatment, there are additional procedures that we need to have in place specific to Telemental Health services. These are for your safety in case of an emergency and are as follows:

* You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, we may determine that you need a higher level of care and Telemental Health services are not appropriate.
* We require an Emergency Contact Person (ECP) who we may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or we will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or we determine it necessary, the ECP agrees to take you to a hospital. Your signature at the end of this document indicates that you understand we will only contact this individual in the extreme circumstances stated above. Please list your ECP here:

Name & relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* You agree to inform your therapist of the address where you are at the beginning of every Telemental Health session.
* You agree to inform your therapist of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a Telemental Health session). Please list this hospital and contact number here:

Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Structure and Cost of Psychosocial Evaluation**

Based on your evaluation needs, your therapist may provide phone, email, or video conferencing (Telemental Health). The evaluation process involves multiple telehealth sessions with a therapist to assess your mental health. These sessions typically last between one to two hours each, with the number of sessions varying between two and four times based on individual needs. Following your final interview, your therapist will have up to 30 days to complete and deliver your psychosocial evaluation. Your therapist will create a comprehensive report combining their clinical observations, assessment results, and any relevant documents you provide. This comprehensive report requires careful attention and analysis, and to ensure the highest quality evaluation, we appreciate your patience during this process. We are committed to providing thorough and accurate assessments to the clients we serve.

After completing the written evaluation, your therapist may contact you briefly over the phone to clarify any details. To ensure accuracy and quality, the report may undergo a review process by the practice owner, supervisor, or a qualified external reviewer. All parties involved adhere strictly to HIPAA regulations to protect your privacy. This additional step helps identify potential oversights and maintain the highest standards of a psychosocial evaluation.

The cost of the psychosocial evaluation is $1,500, covering both the interview sessions with your therapist and the comprehensive written report. Payment can be made in full at the end of your first interview. Alternatively, you may choose to pay a $750 deposit upfront, with the remaining balance due when you are able to schedule your initial interview. Typically, interviews are scheduled at least one week apart, but we understand circumstances may vary. Kindly note that full payment is required before the report is released to your attorney, paralegal, or other designated party.

In the event of an urgent request, you have the option to expedite your evaluation for an additional $500 “rush” fee to ensure that your evaluation receives priority treatment from one of our therapists, guaranteeing delivery by your requested date if it falls before our standard one-month deadline. Please understand that this additional cost is not intended to be opportunistic or exploitative. Given the high volume of cases we handle, this is the only way we can fairly accommodate expedited evaluations. By paying the “rush” fee, your therapist will prioritize your interviews and/or report over those of other clients who have also paid the same amount. This system ensures that we do not show preferential treatment and maintain fairness for all clients. Moreover, the “rush” fee ensures that your therapist is fairly compensated for the additional time and effort required to complete your evaluation sooner than usual. This often involves adjusting their schedule and working outside of regular hours, including overtime work. Additionally, the person responsible for reviewing your evaluation will also need to accommodate this expedited request and will be compensated accordingly.

Your attorney may request that you to write a personal affidavit or letter for your immigration case. We strongly encourage you to try writing this yourself. However, if you find it challenging to articulate your thoughts or the task becomes overwhelming, we offer an affidavit consultation service, where a trained therapist or staff member can assist you in preparing your letter for a fee of $300 per letter. Please note that this consultation is designed to help you express your own words. At no point will the therapist or staff member substitute their words for yours or write it for you. Our role is to guide you by asking the right questions, providing a template, typing as you speak, organizing content, translating, and ensuring proper grammar and syntax.

If your immigration case is experiencing delays, particularly if more than two years have passed since your initial psychosocial evaluation without any response, your attorney may recommend updating your report. We can prepare an addendum for your case at a cost of $600, which serves as an updated report on your mental health since the original assessment. This addendum involves meeting one or two times to re-administer assessments, document any significant events that have occurred since the initial evaluation, and note any updates or changes in your mental health. It will also state whether your diagnoses have remained the same, changed, or worsened.

Cash, personal checks, and credit card are acceptable for payment, and we will provide you with a detailed receipt of payment. We require a credit card ahead of time for the psychosocial evaluation for ease of billing. Please sign the Credit Card Payment Form, which was sent to you separately and indicates that we may charge your card without you being physically present. Your credit card will be charged at the conclusion of the first and second interviews.

**Insurance**

 Immigration psychosocial evaluations are not covered by health insurance. The primary purpose of an immigration psychosocial evaluation is to provide evidence for an immigration case, not to treat a mental health condition. It is important to understand that while these evaluations are essential for many immigration cases, they are considered legal or immigration-related expenses rather than healthcare costs.

**Cancellation Policy**

If you are unable to keep an appointment, you must notify your therapist at least 24 hours in advance. Please note that missed sessions will incur a $75 fee. We understand that unexpected things can happen, and while we may be able to waive this fee once, subsequent missed appointments without proper notice will be charged.

We also understand that plans change. If you need to stop the psychosocial evaluation process for any reason, please let us know. Please understand that even if you withdraw from the process, you agree to allow us to invoice or retain partial payment of the full evaluation cost, as your therapist still needs to be compensated for any time spent and work already completed toward your evaluation, including conducting interviews, scoring assessments, and writing parts of the report. The therapist will generate an invoice detailing the specific time spent on your evaluation until the point of your withdrawal, and the amount will be determined by prorating it at your therapist’s hourly rate. Additionally, your signature below indicates that you understand if you dispute a cancellation charge on your credit card, we will need to provide this document to your credit card company as proof that you agreed to this policy. This would mean that your credit card company would see that you agreed to be treated in our practice. We would not disclose any PHI other than this Informed Consent agreeing to our policies.

**Our Agreement to Conduct a Psychosocial Evaluation**

Please print, date, and sign your name below indicating that you have read and understand the contents of this “Information, Authorization, and Consent to Treatment” form, **as well as the “Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices”** provided to you separately. Your signature also indicates that you agree to the policies of your relationship with your therapist, and you are authorizing your therapist to begin the psychosocial evaluation with you.

 We are sincerely looking forward to helping you throughout this phase of your immigration process and delivering a thorough assessment that accurately reflects your unique situation. If you have any questions about any part of this document, please ask your therapist.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Client Name (Please Print) Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Client Signature**

**If Applicable:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Parent’s or Legal Guardian’s Name (Please Print) Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Parent’s or Legal Guardian’s Signature**

 Alan Behrman & Associates, PC

 2876 Johnson Ferry Rd., Suite 150 Marietta, GA 30062

 1041 Cambridge Square, Suite A Alpharetta, GA 30009

 4855 River Green Pkwy, Suite 330 Duluth, GA 30096

 2517 Jena St. New Orleans, LA 70115

info@alanbehrman.com 770-361-7864 www.alanbehrman.com

**CONSENT & AUTHORIZATION TO RELEASE INFORMATION**

If there are other parties that may assist in the evaluative process, and you believe it would be helpful for your therapist to contact them regarding your psychosocial evaluation, please read carefully and complete this document.

The following is an authorization for the stated parties to consult with one another regarding your psychosocial evaluation. Information shared is for the sole purpose of facilitating this evaluation to you as the client. Please provide the necessary information and your signature with today’s date as indicated below.

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

I, **\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(client)**, hereby authorize **\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(therapist)**, and the following party or parties to discuss my mental health treatment information and share records obtained in the course of psychotherapy treatment, including, but not limited to, therapist’s diagnosis and the written report:

**Attorney:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Paralegal/Legal Assistant:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Law Firm/Company:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note that the psychosocial evaluation is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

Please indicate your preference regarding the information to be shared:

\_\_\_\_ The parties stated above may discuss my medical and/or mental health information

 without limitations.

 \_\_\_\_ I would prefer to limit the information shared between the parties stated above. The

 limitations I would like to make are as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additionally, the above-named parties, therapist & person(s) or entity (entities) designated on this form, agree to exchange information only between themselves (and/or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless the therapist stated above has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by the above-named therapist to be effective.

**Client’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent’s/Legal Guardian’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Health Insurance Portability and Accountability Act (HIPAA)**

**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**

**I. COMMITMENT TO YOUR PRIVACY:**  *ALAN BEHRMAN & ASSOCIATES, LLC* (henceforth referred to as “This Practice”) is dedicated to maintaining the privacy of your protected health information (PHI) and electronic protected health information (ePHI) (henceforth condensed and referred to as simply PHI). PHI is information that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services either in paper or electronic format. This Notice of Privacy Practices (“Notice”) is required by law to provide you with the legal duties and the privacy practices that This Practice maintains concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

**II. LEGAL DUTY TO SAFEGUARD YOUR PHI:** By federal and state law, This Practice is required to ensure that your PHI is kept private. This Notice explains when, why, and how This Practice would use and/or disclose your PHI. Use of PHI means when This Practiceshares, applies, utilizes, examines, or analyzes information within its practice; PHI is disclosed when This Practice releases, transfers, gives, or otherwise reveals it to a third party outside of This Practice*.* With some exceptions, This Practice may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, This Practice is always legally required to follow the privacy practices described in this Notice.

**III. CHANGES TO THIS NOTICE:**  The terms of this notice apply to all records containing your PHI that are created or retained by This Practice. Please note that This Practice reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that This Practice has created or maintained in the past and for any of your records that This Practice may create or maintain in the future. This Practice will have a copy of the current Notice available in a visible location or on our website at all times, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of This Practice’s Notice of Privacy Practices.

IV. HOW This Practice MAY USE AND DISCLOSE YOUR PHI: This Practice will not use or disclose your PHI without your written authorization, except as described in this Notice or as described in the “Information, Authorization and Consent to Treatment” document. Below, you will find the different categories of possible uses and disclosures with some examples.

**1. For Treatment:** This Practice may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed healthcare providers who provide you with healthcare services or are otherwise involved in your care. Example: If you are also seeing a psychiatrist for medication management, This Practice may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, This Practice will always ask for your authorization in writing prior to any such consultation.

**2. For Health Care Operations:** This Practice may disclose your PHI to facilitate the efficient and correct operation of its practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

**3. To Obtain Payment for Treatment:** This Practice may use and disclose your PHI to bill and collect payment for the treatment and services This Practice provided to you. Example: This Practice might send your PHI to your insurance company or managed health care plan to get payment for the health care services that have been provided to you. This Practice could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for This Practice’s office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, This Practice will always do its best to reconcile this with you first prior to involving any outside agency.

**4. Employees and Business Associates:** There may be instances where services are provided to This Practiceby an employee or through contracts with third-party “business associates.” Whenever an employee or business associate arrangement involves the use or disclosure of your PHI, This Practicewill have a written contract that requires the employee or business associate to maintain the same high standards of safeguarding your privacy that is required of This Practice*.*

***Note:*** Federal law provides additional protection for certain types of health information, including **alcohol or drug abuse, mental health, and AIDS/HIV,** and may limit whether and how This Practice may disclose information about you to others.

**V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES – This Practice may use and/or disclose your PHI without your consent or authorization for the following reasons:**

1. **Law Enforcement:** Subject to certain conditions, This Practice may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or law enforcement.Example: This Practice may make a disclosure to the appropriate officials when a law requires This Practice to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **Lawsuits and Disputes:** This Practicemay disclose information about you to respond to a court or administrative order or a search warrant. This Practice may also disclose information if an arbitrator or arbitration panel compels disclosure,when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. This Practice will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate attorney to quash the subpoena or court order protecting the information requested.
3. **Public Health Risks:** This Practice may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.
4. **Food and Drug Administration (FDA):** This Practicemay disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.
5. **Serious Threat to Health or Safety:** This Practicemay disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others and if This Practice determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, This Practicemay provide PHI to law enforcement personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.
6. **Minors:** If you are a minor (under 18 years of age), This Practicemay be compelled to release certain types of information to your parents or guardian in accordance with applicable law.
7. **Abuse and Neglect:** This Practice may disclose PHI if mandated by local child, elder, or dependent adult abuse and neglect reporting laws. Example: If This Practicehas a reasonable suspicion of child abuse or neglect, This Practicewill report this to the appropriate authorities.
8. **Coroners, Medical Examiners, and Funeral Directors:** This Practicemay release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death, or perform other duties as authorized by law. This Practice may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.
9. **Communications with Family, Friends, or Others:** This Practicemay release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under or other law to make health-related decisions for you), or any other person you identify, relevant to that person’s involvement in your care or payment related to your care. In addition, This Practice may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.
10. **Military and Veterans:** If you are a member of the armed forces, This Practice may release PHI about you as required by military command authorities. This Practice may also release PHI about foreign military personnel to the appropriate military authority.
11. **National Security, Protective Services for the President, and Intelligence Activities:** This Practicemay release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law.
12. **Correctional Institutions:** If you are or become an inmate of a correctional institution, This Practice may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others.
13. **For Research Purposes:** In certain limited circumstances, This Practicemay use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.
14. **For Workers' Compensation Purposes:**

This Practicemay provide PHI in order to comply with Workers' Compensation or similar programs established by law.

1. **Appointment Reminders:** This Practiceis permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that you may need or that may be of interest to you.
2. **Health Oversight Activities:** This Practicemay disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with laws. Example: When compelled by the U.S. Secretary of Health and Human Services to investigate or assess This Practice’s compliance with HIPAA regulations.
3. **If Disclosure is Otherwise Specifically Required by Law.**
4. **In the Following Cases, This Practice Will Never Share Your Information Unless You Give Us Written Permission:** Marketing purposes, sale of your information, most sharing of psychotherapy notes, and fundraising. If we contact you for fundraising efforts, you can tell us not to contact you again.

**VI. Other Uses and Disclosures Require Your Prior Written Authorization:** In any other situation not covered by this notice, This Practice will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying This Practice in writing of your decision. You understand that This Practice is unable to take back any disclosures it has already made with your permission, This Practice will continue to comply with laws that require certain disclosures, and This Practice is required to retain records of the care that its therapists have provided to you.

VII. RIGHTS YOU HAVE REGARDING YOUR PHI:

**1. The Right to See and Get Copies of Your PHI either in paper or electronic format:** In general, you have the right to see your PHI that is in This Practice’s possession or to get copies of it. You will also be allowed to inspect your PHI in person and take notes or photographs of their PHI. However, you must request the above in writing. If This Practicedoes not have your PHI but knows who does, you will be advised how you can get it. You will receive a response from This Practice within 15 days of receiving your written request. Under certain circumstances, This Practice may feel it must deny your request, but if it does, This Practice will give you, in writing, the reasons for the denial. This Practice will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged a reasonable fee per page and the fees associated with supplies and postage. This Practice may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

**2. The Right to Request Limits on Uses and Disclosures of Your PHI:** You have the right to ask that This Practice limit how it uses and discloses your PHI. While This Practice will consider your request, it is not legally bound to agree. If This Practice does agree to your request, it will put those limits in writing and abide by them except in emergency situations. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. You do not have the right to limit the uses and disclosures that This Practice is legally required or permitted to make.

**3. The Right to Choose How This Practice** **Sends Your PHI to You:** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). This Practice is obliged to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience.

**4. The Right to Get a List of Disclosures.** You are entitled to a list of disclosures of your PHI that This Practice has made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you or to your family; neither will the list include disclosures made for national security purposes or to corrections or law enforcement personnel. The request must be in writing and state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003.

 This Practice will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a description of the information disclosed, and the reason for the disclosure. This Practice will provide the list to you at no cost unless you make more than one request in the same year, in which case it will charge you a reasonable sum based on a set fee for each additional request.

**5. The Right to Choose Someone to Act for You:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

**6. The Right to Amend Your PHI:** If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that This Practice correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of This Practice receipt of your request. This Practice may deny your request, in writing, if it finds that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, (c) not part of its records, or (d) written by someone other than This Practice. Denial must be in writing and must state the reasons for the denial. It must also explainyour right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and This Practice denial be attached to any future disclosures of your PHI. If This Practice approves your request, it will make the change(s) to your PHI. Additionally, This Practice will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

**6. The Right to Get This Notice by Email:** You have the right to get this notice by email. You have the right to request apaper copy of it as well.

**7. Submit all Written Requests:** Submit to This Practice’s Director and Privacy Officer, **Cristina Lázaro,** at the address listed on top of page one of this document.

VIII. COMPLAINTS: **If you are concerned your privacy rights may have been violated, or if you object to a decision This Practice made about access to your PHI, you are entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services Office of Civil Rights. This Practice will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.**

**Please discuss any questions or concerns with your therapist.** Your signature on the “Information, Authorization, and Consent to Treatment” (provided to you separately) indicates that you have read and understood this document.

**IX. This Practice Responsibilities:** We are required by law to maintain the privacy and security of your PHI. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

***Date of Last Revision: 9/22/23***

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# **CREDIT CARD AUTHORIZATION**

**Client Name as it Appears on Card:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Card Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Expiration Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Security Code (CVV):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit Card Billing Information:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Address

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State Zip Code

Your signature below indicates that you agree to allow your therapist to make charges on your card without you present and to store this information in an electronically encrypted HIPAA-compliant manner. These charges will appear on your bank/credit card statement as ALAN BEHRMAN & ASSOCIATES. You have the right to request a paper copy of this document.

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify ALAN BEHRMAN & ASSOCIATES, PC in writing of any changes in my account information or termination of this authorization.

**Client Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_