THANK YOU FOR CHOOSING OUR OFFICE

Your appointment will be conducted through telehealth. For the telehealth appointment, you will need a computer or a device such as a smartphone, with good Internet connection, a webcam and speakers. Please make sure our office has a current phone number and your email as you will receive an email with all the information you will need to reach your provider for your telehealth appointment.

The following are the forms you will need to review and complete prior to your first appointment with Eric Gilbreath, MD. All these forms are fillable via the computer. We will need these forms returned before your appointment so once you fill them out, please either print and mail them to our office, or fax them to us at 208-323-9604 or save them on your computer and email them to us at newpatients@sage-healthcare.com

1. **Child Intake Form (For child patients only)**
2. **Financial Agreement Form**
3. **Policy and Procedure Form**
4. **Notice of Privacy Practices**
5. **Acknowledgment/Message Permission Form**
6. **Release of Information Form**
7. **Telehealth Consent**

If you have insurance you wish us to bill, please call us with your insurance information. If you have any questions about your first appointment or in general, the answer may possibly be found on our website under "*Frequently Asked Questions*" or please call our office at 208-323-1125.

(#1). **Child Intake Form**: If the patient is under the age of 18, please fill out this form and bring to the first appointment

Initial Child Consultation Form

This information will be used for evaluation purposes and will become part of the psychiatric record.
All information will be kept confidential.

Personal Information

Child's Name: _____ Age: _____ Grade: _____

Father's Name: _____ Occupation: _____

Mother's Name: _____ Occupation: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

_____ Cell Phone: _____

Permission to Leave Message: Yes ☐ No ☐

I do ☐ do not ☐ give permission for my child's photograph to be taken for his/her chart.

Child's Strengths, Hobbies and Interests: _____

_____

_____

_____

Why are you bringing your child in for a psychiatric evaluation? _____

_____

_____

_____

Please briefly list your major concerns regarding your child's behavior/mental health: _____

_____

_____

_____

Has your child been exposed to any recent stresses or changes? If so, please list them: _____

_____

_____

_____

_____

Please list any information regarding your child's past psychiatric/behavioral treatment. (Evaluations, with whom, when, and results):

Name/Address of Past Provider	Dates of Treatment	Purpose of Treatment

Psychiatric Medications: (List past medications and reasons for stopping/changing.) (List current medications – doses and times):_____

_____

_____

_____

Often loses temper: Yes ☐ No ☐ If yes, how often? _____ How long do the episodes usually last? What does your child do during these episodes? What usually triggers the tantrums? How do you usually intervene? _____

_____

_____

_____

Has your child ever been physically abused? Yes ☐ No ☐ If yes, please give details: _____

_____

_____

_____

Has your child ever been sexually abused? Yes ☐ No ☐ If yes, please give details: _____

_____

_____

_____

Does your child express any unusual fears? Yes ☐ No ☐ If yes, please give details: _____

_____

_____

_____

Has your child ever complained of hallucinations? (e.g. hearing voices, seeing things) Yes ☐ No ☐

If yes, please give details: _____

_____

_____

Has your child exhibited paranoia? (Worries that others are out to hurt him/her) Yes ☐ No ☐

If yes, please give details: _____

_____

DEVELOPMENTAL HISTORY:

Was pregnancy for this child planned? Yes ☐ No ☐

What was the mother's mood during this pregnancy? _____

_____

_____

_____

Was the mother healthy during pregnancy with this child? Yes ☐ No ☐

Was the mother involved in any accidents or falls during pregnancy? Yes ☐ No ☐

If yes, please give details: _____

_____

_____

_____

During pregnancy did the mother use?

Prescription medications? Yes ☐ No ☐ _____

Over the counter medications? Yes ☐ No ☐ _____

Alcohol? Yes ☐ No ☐ (if yes, what kind and amount) _____

Illegal Drugs? Yes ☐ No ☐ _____

Tobacco/cigarettes? Yes ☐ No ☐ (If yes, how many packs a day?) _____

Any problems with labor and delivery? Yes ☐ No ☐ If yes, please give details: _____

_____

_____

What was the weight of the baby at birth? _____

Was the baby born full term? Yes ☐ No ☐
(If not, how much earlier or later did the baby arrive?) _____

How long did mother and baby stay in the hospital? _____

DEVELOPMENT OF CHILD:

At what age did the child:

Sit up alone _____ Toilet training started at what age: _____

Stand _____ At what age was bowel control established? _____

Crawl _____ When did bed-wetting stop? _____

Take first steps _____ When did wetting in day-time stop? _____

Walk unaided _____ Were there any lapses? Yes ☐ No ☐

Speak isolated words (da da) _____ If so, at what age? _____ Speak in simple phrases _____

Did the child have difficulty with speech and/or language development? Yes ☐ No ☐ (if yes, please give age and explanation) _____

_____

MEDICAL HISTORY:

Allergies: _____

Pediatrician: _____ Last physical exam: _____

Current medications: _____

_____

_____

Medical hospitalization(s): _____

_____

Surgeries: _____

_____

Are immunizations up to date? Yes ☐ No ☐

Traumatic Injuries *(e.g.– broken bones, loss of consciousness, etc.*) _____

_____

_____

Chronic Illnesses: _____

_____

_____

Is your child currently experiencing any physical pain or discomfort? Yes ☐ No ☐ *If yes, please indicate severity of current pain on a scale of 1 (mild) to 10 (severe):* _____

_____

_____

Seizures: _____

_____

_____

Has child experimented with or used: (if yes, please list amount and frequency)

Substance	Date last used	Age first used	Amount and frequency
Cannabis			
Cocaine			
Alcohol			
Opiates/Methadone			
Hallucinogens			
Designer (G, Ecstasy)			
Inhalants			
Cigarettes			
Caffeine			
Benzodiazepines			
Methamphetamines			
Other			

FAMILY HISTORY:

Mother: Age: _____

History of mental health problems: _____

_____

_____

Education: _____ Occupation: _____

History of mental illness, legal problems, drug/alcohol problems, suicides, etc., in any relatives: _____

_____

Father: Age: _____

History of mental health problems: _____

_____

_____

Education: _____ Occupation: _____

History of mental illness, legal problems, drug/alcohol problems, suicides, etc., in any relatives: _____

_____

Brothers/Sisters: Names and ages: _____

_____

Any mental health problems: _____

_____

_____

Where are they living? _____

Who is the child living with? (If not living with the biological parents, why?): _____

_____

Besides the care givers, are there other children or adults living in the home? (If yes, please give explanation) _____

_____

_____

SOCIAL HISTORY:

Does your child have friends? _____

Does your child participate in any organized activities or sports? _____

_____

How does your child do when playing with other children? _____

_____

Do you know if your child sexually active? _____

Does your child have any hobbies? _____

_____

What does your child do with his/her free time? _____

_____

How does your child do when playing with other children? _____

_____

Does child have any legal charges/involvement with the juvenile justice system? Yes ☐ No ☐ *If yes, please explain*:

_____

_____

_____

Does your child have a part-time job? Yes ☐ No ☐ _____

SCHOOL HISTORY:

Current School: _____ Current Grade: _____

Names of different Schools attended (list dates and grades): _____

_____

Any early problems with:

Academics: _____

_____

Conduct: _____

_____

Motivation: _____

_____

Any current problems with:

Academics: _____

_____

Conduct: _____

_____

Motivation: _____

_____

Any grades repeated? _____

Any problems with: Truancy ☐ Suspension ☐ Expulsion ☐ _____

_____

LEARNING DISABILITIES:

Has/does your child receive(d) any special services in school? _____

_____

_____

OTHER COMMENTS: _____

_____

_____

Check all that apply

- ☐ Fails to give close attention to details; careless mistakes
- ☐ Difficulty sustaining attention
- ☐ Does not seem to listen when spoken to directly
- ☐ Does not follow through on instructions; fails to complete tasks
- ☐ Avoidant of tasks that require sustained mental effort
- ☐ Often loses things
- ☐ Easily distracted by things less important
- ☐ Forgetful in daily activities
- ☐ Fidgets with hands/feet, squirms in seat
- ☐ Cannot remain seated
- ☐ Runs about or climbs excessively
- ☐ Difficulty playing or engaging in other activities quietly
- ☐ Often on the go
- ☐ Often talks excessively
- ☐ Blurts out answers
- ☐ Difficulty awaiting turn
- ☐ Often interrupts or intrudes
- ☐ Bullies, intimidates, or threatens others
- ☐ Initiates physical fights
- ☐ Child used a weapon or dangerous object against self or others
- ☐ Physically cruel to people
- ☐ Physically cruel to animals
- ☐ Sexual acting out or sexually inappropriate behavior
- ☐ Deliberately engaged in fire-setting
- ☐ Deliberately destroyed other property
- ☐ Broken into someone else's home
- ☐ Lies excessively
- ☐ Stealing or shoplifting
- ☐ Bed wetting
- ☐ Soiling or wetting pants during day
- ☐ Stays out at night or all night without permission
- ☐ Has run away from home
- ☐ Often truant from school
- ☐ Often argues with adults
- ☐ Actively defies rules/refuses to comply with requests
- ☐ Often deliberately annoys people
- ☐ Often blames others
- ☐ Touchy/easily annoyed by others
- ☐ Angry and resentful
- ☐ Spiteful and vindictive
- ☐ Irritable mood
- ☐ Appetite changes
- ☐ Activity level changes
- ☐ Physical complaints with no real medical problem confirmed
- ☐ Low energy level
- ☐ Lots of energy for certain periods of time
- ☐ Able to stay up for days without sleep
- ☐ Frequent crying
- ☐ Tries to isolate self from others
- ☐ Physical restlessness during sleep
- ☐ Problems falling asleep
- ☐ Gory dreams/nightmares
- ☐ Difficulty getting up in the morning
- ☐ Frequent fights
- ☐ Problem with destructiveness
- ☐ Hostile and rejecting attitude
- ☐ Confused thinking
- ☐ Racing thoughts
- ☐ Over eating/over weight
- ☐ Anorexia/under eating – under weight
- ☐ Bulimia (makes self vomit)

Form completed by: _____ Date: _____

FINANCIAL AGREEMENT

Provider**: Eric Gilbreath, MD**

CLIENT INFORMATION Preferred Pronouns: ☐ she/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other: Please specify:_____

Legal Patient Name_____DOB_____SS#_____

Address_____City_____State_____ Zip_____

Phone #_____Can we leave messages at this number: Yes____☐__No____☐

Gender Assigned at Birth: F____☐__M____☐ Other_____Decline to Answer____☐____Marital Status: S____☐ D____☐ W____☐ Other_____

Current Gender: F____☐__M____☐ Other_____Decline to Answer____☐____Preferred Name: _____

Employer:_____Work Phone#_____

Address_____City_____State_____ Zip_____

SPOUSE/PARTNER INFORMATION: Name**:** _____DOB_____SS#_____

Employer:_____Work Phone#_____

FINANCIAL RESPONSIBLE (If other than Client)

Name_____DOB_____SS#_____

Address_____City_____State_____ Zip_____

Ph#_____Employer: _____Work#_____

EMERGENCY CONTACT: Name_____DOB_____SS#_____

Address_____City_____State_____ Zip_____Ph#_____

INSURANCE INFORMATION

Primary Insurance_____ Policyholder Name_____

Policyholder ID#_____ Group #_____ Employer_____

Secondary Insurance_____ Policyholder Name_____

Policyholder ID#_____ Group #_____ Employer_____

OFFICE POLICY: Payment is due at the time of service. You are responsible for all fees regardless of insurance coverage. We charge $25.00 for all returned checks. As a courtesy, we will submit claims to the above-named insurance company. Benefits quoted by your insurance company are not a guarantee of payment. If your insurance company has not paid your claim within 60 days, the payment of the claim will be your responsibility. We do not bill for the following: student insurance, retroactive Medicaid, victims and workers' compensation, or third parties listed in divorce decrees. All minors must be accompanied by a parent or legal guardian. If your insurance company requires an authorization or referral for your visit, you are responsible to obtain and maintain the authorization or referral. Our providers do not do disability paperwork or FMLA until you have been an established patient for at least 6 months.

ASSIGNMENT OF BENEFITS: I request that payment of authorized insurance benefits be made on my behalf to Sage Health Care or the provider of my choice for any services furnished to me by that provider. I authorize the holder of medical information about me or any information needed to determine these benefits to be released to the insurance company(s) listed above.

Policyholder Signature or Responsible Party_____Date_____

ERIC GILBREATH, MD - POLICY AND PROCEDURE

Welcome to Dr. Gilbreath's private practice located within Sage Health Care, PLLC. Dr. Gilbreath sees private practice patients at this location; however, his practice is a separate company from Sage. Our office is committed to giving you excellent service and treatment. The following are his policies and practices which are required to be read and sign prior to any treatment. Please let us know if you have any questions or concerns.

REGARDING PAYMENT/INSURANCE:

Full payment or co-payment is required at the time of service. We accept cash, check or credit card.

Your insurance policy is a contract between you and your insurance company. We are not a part to that contract, but will bill your primary insurance as a service to you. If your insurance has not paid your claim in full within sixty days of billing, we will require the balance to be paid by you.

Dr. Gilbreath does not accept all insurances so please make sure to check with the office prior to coming in if the doctor accepts the insurance you have. If you have applied for workers' compensation benefits, we will assist you in any way we can but require that you keep your account current at all times. If you are receiving assistance from your church or a charity organization, please talk with the billing office before scheduling your appointment.

OFFICE HOURS: Our office is open Monday – Thursday 8:00 am to 5:00pm and Friday 8:00am to 3:00 pm

EMERGENCY SITUATIONS: For after hour emergencies, please call 911 or go to your local emergency room.

UNATTENDED CHILDREN:
Please note that our office does not allow and are not responsible for unattended children in the lobby.

CANCELLATION AND NO SHOW POLICY: If you need to cancel or change your appointment, please do so as soon as possible. If cancellation does not occur at least 24-hours in advance or you no show for the appointment, you may be charged for that appointment.

MEDICATION REFILLS: Please call your pharmacy for all refill requests. You will need the following information to give to them: your name, phone number, date of birth, date of last refill, name of physician, name and dosage of medication and the date of your next appointment. Please take a moment to look at your current prescription bottle to ensure that you do not have a refill waiting at your pharmacy. Please keep in mind that we require a 48-hour notice for all non-controlled substance medication refills and a 72-hour notice for all controlled substance medication refills.

PHONE CONSULTS: If you need to speak with the nurse, there may be a fee charged for this service. The fees range from $5.00 to $20.00 depending upon the length of time spent with the nurse.

REASONS FOR TERMINATION OF CLINICIAN-PATIENT RELATIONSHIP:

1. If you feel you are not compatible with your clinician, arrangement can be made to be seen by another provider
2. If you are not complying with your clinician orders, he/she may request to discontinue treatment
3. If you are not meeting financial obligations, your clinician may discontinue treatment
4. If you are disruptive or inappropriate towards the staff, care may be terminated
5. Dishonesty and/or deceitfulness may require termination of treatment

I have read the above policies and practices. I understand and agree to comply with the above.

_____ _____

Patient/Guardian Date

NOTICE OF PRIVACY PRACTICES

Eric Gilbreath, MD, PA
413 N. Allumbaugh, Suite 101, Boise, ID 83704

Effective Date: 9/13/2021

Privacy Officer: Brenda Schwartz
208-954-5579
413 N. Allumbaugh, Suite 101, Boise, ID 83704
brenda.schwartz@sage-healthcare.com

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

TABLE OF CONTENTS

A. How This Medical Practice May Use or Disclose Your Health Information .....

B. When This Medical Practice May Not Use or Disclose Your Health Information .....

C. Your Health Information Rights.....

1. Right to Request Special Privacy Protections
2. Right to Request Confidential Communications
3. Right to Inspect and Copy
4. Right to Amend or Supplement
5. Right to an Accounting of Disclosures

6. Right to a Paper or Electronic Copy of this Notice

D. Changes to this Notice of Privacy Practices .....

E. Complaints.....

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart, and/or on a computer, and/or in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our transcription service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.]

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect;

reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be

transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

22. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

23. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an

alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or

received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Linda Yuu Connor, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
2201 Sixth Avenue - M/S: RX-11
Seattle, WA 98121-1831
Voice Phone (800) 368-1019
FAX (206) 615-2297
TDD (800) 537-7697

Or email: OCRMail@hhs.gov

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.

Acknowledgement Message Permission Form: Please fill out and bring to first appointment

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices

_____ _____

Signature Date

Relationship to Patient if signed by someone other than patient:

Parent ☐ Guardian ☐ Other:_____

Permission to Leave Messages

By signing below, I give the staff at Sage Health Care, PLLC permission to leave detailed appointment information on my answering machine at the phone number(s) that I have provided to their office. I understand that I have the right to revoke this authorization at any time.

_____ _____

Patient Signature or legal Guardian Date

_____ _____

Printed Name Date

Release of Information Form: Please fill out and return to our office if you wish us to obtain or disclose information about your care

R070616

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name:_____**DOB**_____

I hereby authorize (*name of your provider*) Eric Gilbreath, MD **and the employees at Sage to use and or disclose my individually identifiable Protected Health Information ("PHI") in the manner described below. I understand that the person or entity receiving my PHI, may re-disclose my PHI, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.**

☐ Obtain information from: AND/OR ☐ Disclose information to:

Name and Address:_____

_____Phone #:_____

Category and Time Period of PHI

Please initial the Category of PHI you wish to release

☐ Initial Evaluation ☐ Claims/Billing Information ☐ Lab Results

☐ Progress Notes ☐ Therapy notes ☐ Entire Medical Record

☐ other_____

Time period of healthcare treatment records you wish to be included:

☐ Anytime ☐ Healthcare provided between (date)_____ and (date) _____

Limit of PHI

I understand that this authorization extends to all of any part of the records/information designated above which may include treatment for physical and mental illness, alcohol/drug abuse; HIV/AIDS test results or diagnosis. I understand that if I wish to limit the use and disclosure of my PHI, I would have indicated below by initialing the appropriate category of PHI I *DO NOT* wish to be released.

_____ HIV/AIDS test results or diagnosis _____Alcohol/drug abuse _____ Other_____

Please limit the use and disclosure of my PHI to only include the following dates:_____

[Example: laboratory results from July 1998; mental health records from January 2001 to present"]

Purpose of PHI

☐ Continuity of Care ☐ Aftercare Planning

☐ Contact with Referring Supervisor ☐ Referral

☐ Family Involvement ☐ Other_____

I understand that this authorization will expire on the following date or event:_____
If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying the above provider in writing. I understand that my revocation or modification of this authorization will not effect any actions taken by the provider mentioned above in reliance on this authorization before the provider mentioned receives my request for revocation or modification. I must sign my written request and send it to: 413 N Allumbaugh Street, Suite 101, Boise, ID 83704

Signed:_____Date:_____

If not signed by the patient, please indicate authority or relationship:_____

Note to Agency/Person receiving information: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR Part 2.1) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Eric Gilbreath, MD
413 N Allumbaugh Street, Ste 101
Boise ID 83704
208-323-1125

As we navigate through the COVID-19 pandemic, our office will be temporarily closed for face-to-face appointments. Your appointment will be temporarily conducted through telehealth. For the telehealth appointment, you will need a computer or a device such as a smartphone, with good internet connection, a webcam and speakers. Please make sure our office has a current phone number and your email as you will receive an email with all the information you will need to reach your provider for your telehealth appointment.

This document is intended to inform you about telehealth practices, risks and benefits. Telehealth means the mode of delivering your mental health services via technology assisted media such as but not limited to telephone or synchronous video conferencing.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (ie. Poor resolution of images) to allow for appropriate medical decision making
- Appointment delays due to failure of the equipment
- In very rare instances, security protocols could fail though our office still is upholding HIPAA standards

Your Responsibilities for Confidentiality and TeleHealth

Please consider what information you are communicating and through what devices and their security. If we are conducting your visit via synchronous video it is your responsibility to choose a secure location for the call. Please be aware that family, friends, employers, coworkers, 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 TeleHealth sessions or keep any such recordings on any devices.

Equipment Needed and Expectations

1. You will need at minimum a bandwidth connection of 384 kb or higher.
2. Minimum resolution of 640x360 at 30 frames per second.
3. Operational web camera (HD 1080p is recommended).

4. Proper lighting and seating to ensure a clear image of each party's face.
5. Dress and environment appropriate to an in-office visit.
6. Only agreed upon participants will be present.

In Case of Technology Failure

During a TeleHealth session we may encounter technological failure. If this happens during a session we will try to reestablish connection through another platform. If it appears that this is not possible the most reliable back up plan is to contact one another via telephone. Please make sure you have a phone with you and that I have your phone number.

If for some reason we are on a phone session and we get disconnected please call me back or contact me to schedule another session.

If we lose connection and are not able to reach one another and you are in a crisis, please call the suicide prevention line at 208-398-4357, or call 911 or go to your local emergency room.

Crisis Planning Information

Emergency contact: _____ Phone: _____

Address/Location of TeleHealth Sessions: _____

Consent to TeleHealth Treatment

I agree to receive Tele Health services and have been informed of the risks and benefits and limitations surrounding TeleMental Health.

By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification.

_____ _____

Signature of Patient or parent if patient is a minor: Date

Once signed, please either mail to us 413 N Allumbaugh Ste 101 Boise ID 83704, fax to 208-323-9604 or email to newpatients@sage-healthcare.com

Thanks.