BLOOM WOMEN'S WELLNESS

# Client Intake Form

## Client Information

Name(s):

Address:

City: State: Zip Code:

Date of Birth: Age:

Phone #: Email:

Is it ok to leave messages at this phone number? ☐ Yes ☐ No

Would you like to be added to our email list? ☐ Yes ☐ No

May we contact you via email? ☐ Yes ☐ No

Emergency Contact Name: Phone #:

RACE:

☐ White ☐ Black/African American ☐ Asian ☐ Latinx/Hispanic ☐ Native American ☐ Multi-racial

BIRTH SEX:

☐ Female ☐ Male ☐ Intersex ☐ Prefer not to disclose

GENDER:

☐ Female ☐ Male ☐ Non-binary ☐ Transgender ☐ Prefer not to disclose

## Insurance Information: We accept Wellmark, Anthem, Cigna, and Midlands Choice plans

Primary Insurance: Phone #:

Insured Name: Date of Birth: Primary policy holder:

Mobile #: Group #: Employer #:

## Family Information

MARITAL STATUS:

☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated ☐ _____

Spouse/Partner: Age: Lives with you? ☐ Yes ☐ No

## Family Information

How satisfied are you with your relationship?

☐ Very Satisfied ☐ Satisfied ☐ Neutral ☐ Unsatisfied ☐ Very Unsatisfied

Do you have children? ☐ Yes ☐ No If no, please skip to the next section.

| | | | | |
|---|---|---|---|---|
| Child's Name: | Age: | Lives with you? | ☐ Yes | ☐ No |
| Child's Name: | Age: | Lives with you? | ☐ Yes | ☐ No |
| Child's Name: | Age: | Lives with you? | ☐ Yes | ☐ No |
| Child's Name: | Age: | Lives with you? | ☐ Yes | ☐ No |

## Family History

Who were you raised by:

How many siblings do you have:

Please describe your relationship with your parents/caregivers:

Please describe names, ages, and respective relationships with your siblings:

If there are any circumstances from your childhood that you'd like to elaborate on, please do so here:

## Support System

Do you have a support system? ☐ Yes ☐ No

Please explain:

What is your current living situation?

Is your home environment safe? ☐ Yes ☐ No

If no, please explain why:

## Employment/Education Status

Employer/School:

Occupation/Years in School:

Please check all that apply:

- ☐ Disabled
- ☐ Employed Part Time
- ☐ Unemployed
- ☐ Employed Full Time
- ☐ Retired
- ☐ Student

What is your highest level of education completed?

- ☐ Less Than High School
- ☐ Associates Degree
- ☐ Bachelor's Degree
- ☐ High School/GED
- ☐ Some College
- ☐ Post Graduate Degree

## Mental Health History

Have you experienced any of the following in the past 90 days? Please check all that apply:

- ☐ ADHD
- ☐ Anger/Rage
- ☐ Anxiety
- ☐ Death in Family
- ☐ Depression
- ☐ Hallucinations
- ☐ Hospitalization
- ☐ Obsessive/Intrusive Thoughts
- ☐ Mood Swings
- ☐ Panic/Phobia
- ☐ Paranoia/Delusions
- ☐ Poor Sleep Patterns
- ☐ Racing Thoughts
- ☐ Self Injury
- ☐ Suicide Attempt
- ☐ Thoughts of Harming Others
- ☐ Violence
- ☐ Weight Gain/Loss

Have you experienced abuse? ☐ Yes ☐ No

If yes please explain:

Have you ever been admitted to the hospital for mental health reasons? ☐ Yes ☐ No

If yes please explain:

Is there any family history of mental health problems or suicide (attempts)? ☐ Yes ☐ No

If yes please explain:

Have you had therapy in the past? ☐ Yes ☐ No If yes, was it helpful? ☐ Yes ☐ No

Previous therapist:

Dates seen:

## Medical History

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list:

Do you currently have any medical problems? ☐ Yes ☐ No

If yes, please list all symptoms and treatments you are undergoing:

Do you experience physical pain that causes mental health issues? ☐ Yes ☐ No

Physician: | Phone Number:

Permission to contact physician? ☐ Yes ☐ No

## Stressors

What stressors are you dealing with or have you dealt with in the past? Please check all that apply:

- ☐ Alcohol/Drug Abuse
- ☐ Attempted Suicide
- ☐ Death
- ☐ Debilitating Injuries/Disabilities
- ☐ Divorce
- ☐ Financial Crisis/Unemployment
- ☐ Frequent Relocations
- ☐ Legal Problems
- ☐ Physical/Sexual Abuse
- ☐ Psychiatric Illness
- ☐ Serious illness
- ☐ Other _____

## Personal History

What symptoms are you dealing with? Please check all that apply:

- ☐ Appetite Problems
- ☐ Concentration Problems
- ☐ Energy Levels
- ☐ Flashbacks
- ☐ Hopelessness
- ☐ Low Interest/Motivation
- ☐ Mood Swings
- ☐ Nightmares
- ☐ OCD Symptoms
- ☐ Panic Attacks
- ☐ Thoughts of Self-harm/Suicide
- ☐ Trouble Sleeping
- ☐ Other _____

How long have you been dealing with these?

What effect do these have on your life? ☐ Minimal ☐ Mild ☐ Moderate ☐ Severe

## Habits & Lifestyle

Do you regularly drink alcohol? ☐ Yes ☐ No

If yes, how often:

Are you dealing with any addictions? ☐ Yes ☐ No

If yes, please explain:

How often do you engage in recreational drug use?

☐ Never ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily

Do you consider your alcohol/drug use a problem? ☐ Yes ☐ No ☐ Unsure

Do you exercise regularly? ☐ Yes ☐ No

If yes, please describe what you do and how often:

Do you have hobbies? ☐ Yes ☐ No

If yes, what are they and how often do you do them?

What do you do for fun?

## Habits & Lifestyle

Have you or are you dealing with any of the following legal issues? Please check all that apply:

- ☐ Custody/Divorce
- ☐ Fraud
- ☐ Substance Abuse
- ☐ Driving Offenses
- ☐ Immigration
- ☐ Violence

Have you ever been imprisoned? ☐ Yes ☐ No

If yes, please explain:

Are you court ordered for services? ☐ Yes ☐ No If no, please skip to the next section.

Are you assigned to a probation officer or case worker? ☐ Yes ☐ No

If yes, please list them here:

Name: Phone Number:

Will you require progress reports for legal authorities? ☐ Yes ☐ No

By signing below, I agree to the following:
I have completed this form to the best of my ability and knowledge. I agree to inform the therapist of any changes in the above information.

| Name Printed | Signature | Date |
|---|---|---|

## Goal Information

Please answer the following questions to the best of your ability:

Why are you seeking treatment at this time?

What would you like to change about yourself or your circumstances?

What gives you hope, purpose, and meaning?

What do you hope to get from treatment & how did you hear about us?
Would you be comfortable with an intern present?

BLOOM WOMEN'S WELLNESS

# Payment Information & Authorization

## Scheduling Information

Please check all the appointment days and times that are ideal for you:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | Monday | ☐ AM | ☐ PM | ☐ | Thursday | ☐ AM | ☐ PM |
| ☐ | Tuesday | ☐ AM | ☐ PM | ☐ | Friday | ☐ AM | ☐ PM |
| ☐ | Wednesday | ☐ AM | ☐ PM | ☐ | Weekend | ☐ AM | ☐ PM |

## Payment Information

Please see below for the rates per session ☐ Cash ☐ Check ☐ Credit Card

## Credit Card Authorization

Please complete all of the fields below if you plan on paying by credit card. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Name on Card: Zip Code:

Credit Card Number: Card Expiration:

Card Type: ☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover ☐ Other

By signing below, I authorize Bloom Women's Wellness to charge the credit card above for agreed-upon purchases and fees. I understand that my information will be saved for future transactions on my account.

Name Printed _____ Signature _____ Date _____

BLOOM WOMEN'S WELLNESS

# Release of Information

## Client Information/Name:

I authorize Bloom Women's Wellness to Send/Receive:

- ☐ Medical History/Evaluations
- ☐ Mental Health information
- ☐ Developmental and/or social history
- ☐ Progress notes and/or treatment summary
- ☐ Medication records
- ☐ Other

## To/From & providers email:

## Your relationship to client (Self, parent/guardian, etc):

The above information will be used for the following purposes:

- ☐ Planning treatment/program
- ☐ Continuing treatment/program
- ☐ Determining eligibility for benefits
- ☐ Case teview/consultation
- ☐ Updating files
- ☐ Other

I understand that this information may be protected by Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 42 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.
I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

| Name Printed | Signature | Date |
|---|---|---|

BLOOM WOMEN'S WELLNESS

# Cancellation and No Show Policy

Your appointment is very important. We understand that sometimes schedule adjustments are necessary. Therefore, we respectfully request at least 24 hours notice prior to your therapy appointment and 48 hours notice prior to your scheduled medication appointment time for cancellations or rescheduling of appointments. Please notify us by e-mail if your cancellation is outside of our normal business hours or if you're unable to reach us by phone at 515-499-4959.

ALL NO-SHOWS AND ANY APPOINTMENTS CANCELLED, RESCHEDULED, OR CHANGED WITHOUT 48 HOURS' NOTICE WILL BE BILLED TO YOUR ACCOUNT IN THE AMOUNT WE WOULD HAVE COLLECTED IF THE SERVICE HAD BEEN PROVIDED AS SCHEDULED.

Please keep in mind that insurance does not reimburse for missed appointments; therefore, you will be responsible for the full payment of the appointment fee. For example, if a therapy session is $185, and you have a $35 copay you would be responsible to pay $185 for a late cancellation or missed appointment.

Please remember that it is your responsibility to remember your appointment dates and times in order to prevent any missed appointments which result in a cancellation fee. Not receiving an electronic notification of your appointments from us is not sufficient reason to miss an appointment if the original confirmation notification was received timely.

It is mutually understood that if a cancellation is due to circumstances beyond any of our control, such as power outage, unfortunate incidence, illness, or weather that requires you or us to have to cancel or be closed during regular business hours, we will reschedule your existing appointment and no discount or rescheduling fee will apply.

ARRIVAL TIME
Please arrive at your appointment at least 5 minutes prior to your scheduled appointment time. All therapy and medication appointments have a specific time schedule. An early arrival allows for a relaxed experience. If you arrive late, your therapy may be shortened in order to maintain our schedule.

LATE ARRIVAL POLICY
All appointments begin and end on time in order to maintain our schedule. If the therapy does not start on time due to client tardiness, the therapy time will be reduced accordingly and you will still be required to pay full price. If a client is more than 15 minutes late, the appointment will be considered a cancellation.

I have read and understood the cancellation and refund policy and agree to abide by the above conditions.

| Name Printed | Signature | Date |
|---|---|---|

BLOOM WOMEN'S WELLNESS

# Practice Policies

APPOINTMENTS AND CANCELLATIONS:
Please remember to cancel or reschedule 24 hours in advance for all therapy appointments and 48 hours in advance for all psychiatric appointments. You will be responsible for a $185 cancellation/no show fee (full session amount) if cancellation is less than 24 hours for your therapy session. If this is a medication management appointment, you will be responsible for a $280 cancellation/no show fee for a missed evaluation or $203 for a missed follow up if cancellation is less than 48 hours. Excessive cancellations and/or 3 or more no-shows/late cancellations will result in future sessions being cancelled and termination of therapy and medication management services. Any Repeated cancellations and no-show patients may be restricted from future bookings. If balance on account exceeds $100, you will not be able to schedule another appointment until it is taken care of and other arrangements are made.
For phone calls, calls that last less than 15 minutes are free of charge. For phone calls that are 15 minutes, they are billed at the self-pay rate of $39.50. For phone calls that are 30 minutes, they are billed at the self-pay rate of $79.00. For phone calls that are 45 minutes, they are billed at the self-pay rate of $118.50. For phone calls that are 60 minutes, they are billed at the self-pay rate of $158.00 or the full rate of an individual therapy session.
For all sessions completed with an intern, sessions are offered at a $25/session rate. For sessions that are not canceled within the 24 hour timeframe, you will be subject to a $25 late charge/no show fee.
A $25.00 service charge will be charged for any checks returned for any reason for special handling.

TELEPHONE ACCESSIBILITY:
If you need to contact me between sessions, please leave a message on my voice mail. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that Face- to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, telehealth sessions are available, and we will discuss this at our initial session. If a true emergency situation arises, please call 911 or any local emergency room.

SOCIAL MEDIA AND TELECOMMUNICATION:
Due to the importance of your confidentiality and the importance of minimizing dual relationships, we do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Instagram, etc). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

BLOOM WOMEN'S WELLNESS

# Practice Policies Cont.

ELECTRONIC COMMUNICATION:
We cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, we will do so. While we may try to return messages in a timely manner, we cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.

MINORS:
If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

TERMINATION:
Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. Bloom Women's Wellness may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. We also hold the right to terminate treatment if there are safety concerns at any point. If therapy is terminated for any reason or you request another therapist, we will provide you with a list of qualified psychotherapists and/or medication providers to treat you. You may also choose someone on your own or from another referral source.
Should you fail to schedule an appointment for six consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, a therapeutic session spot will no longer be available.

| Name Printed | Signature | Date |
|---|---|---|

BLOOM WOMEN'S WELLNESS

# In Case of Emergency- Telehealth

Emergency procedures specific to Telehealth services:

There are additional procedures that we need to have in place specific to Telehealth 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, I may determine that you need a higher level of care and Telehealth services are not appropriate.
I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please enter this person's name and contact information below.
Either you or I 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 I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

PLEASE LIST YOUR ECP & PHONE NUMBER HERE:

_____

PLEASE LIST YOUR HOSPITAL & PHONE NUMBER HERE:

_____

I consent to my therapist/Bloom Women's Wellness, LLC calling the above listed in the event of any safety concern or emergency.

| Name Printed | Signature | Date |
|---|---|---|

BLOOM WOMEN'S WELLNESS

# Informed Consent for Counseling and Medication Management

This informed consent document is intended to provide general information about the counseling services provided by Bloom Women's Wellness. This is a legal document; please read it carefully before signing.

MENTAL HEALTH SERVICES

Bloom Women's Wellness recognizes that it may not be easy to seek help from a mental health professional. It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result

NATURE OF THERAPY & RISKS

It is important to understand that there are both benefits and risks associated with participation in therapy. Therapy may improve the ability to relate to others, provide a clearer understanding of self, values, and goals, and an ability to deal with everyday stress. However, clients often learn things about themselves that they don't like. Often growth cannot occur until past issues are experienced and confronted, often causing distressing feelings such as sadness and anxiety. Therapy can lead to unanticipated feelings and change, which might have an unexpected impact on you, and your relationships. For example, marital therapy may lead to the possibility of exercising additional options.

RELATIONSHIP

The relationship you have with your therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that your therapist not have any other type of relationship with you. It is not appropriate to share gifts, barter, or trade services with your therapist.

CONFIDENTIALITY

Discussions between you and your therapist are confidential. No information will be released without your written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; criminal prosecutions; child custody cases, suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, notify, or disclose. If you have any questions regarding confidentiality, you should bring them to the attention of your therapist when you and the therapist discuss this matter further.

AFTER-HOUR CONCERNS & EMERGENCIES

As a general rule, it is our belief that important issues are better addressed within regularly scheduled sessions. However, you may contact your therapist in between sessions. You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

BLOOM WOMEN'S WELLNESS

# Informed Consent for Counseling and Medication Management Cont.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.
If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.
Unexpected therapist absence: In the event of my unplanned absence from practice, whether due to injury, illness, death, or any other reason, I maintain a detailed Professional Will with instructions for an Executor to inform you of my status and ensure your continued care in accordance with your needs. Please let me know if you would like the names of my Executor and Secondary Executor. You authorize the Executor and Secondary Executor to access your treatment and financial records only in accordance with the terms of my Professional Will, and only in the event that I experience an event that has caused or is likely to cause a significant unplanned absence from practice.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

| Name Printed | Signature | Date |
|---|---|---|

BLOOM WOMEN'S WELLNESS

# Insurance Authorization

I authorize Bloom Women's Wellness, LLC to release information to the insurance companies provided on this form in order to submit insurance claims on my behalf. This authorization extends to the event necessary to obtain payment for services provided to me, and includes authorization to release information about mental health, substance abuse, or HIV diagnoses as required.

In consideration of the services provided to me, I assign all benefits to Bloom Women's Wellness, LLC if accepted and authorize my insurance companies.

I understand that I remain responsible for all amounts due by me, including (but not limited to) copays, coinsurance, deductible amounts, and all services not covered by my insurance plan, and mutually-agreed upon services or fees that are not deemed medically necessary.

I understand that even in the event that Bloom Women's Wellness, LLC may not be in network for a particular plan, they are required to bill these payers first unless insurance is opted out all together and services are under a private pay agreement.

| Name Printed | Signature | Date |
|---|---|---|

BLOOM WOMEN'S WELLNESS

# Opt out of Insurance (Optional)

I, the client, understand that:
• I have voluntarily selected to not use my insurance for my counseling sessions; My therapist did not encourage, initiate, coerce, persuade, imply, or otherwise cause me to opt out of my insurance either verbally or otherwise; the decision is my own for my own reasons;
• I am not opting out of using my insurance to gain a specific time slot or any auxiliary benefits provided by my therapist either implied or otherwise; • My treatment -- either starting, initiating or ongoing, was not threatened in any way by either signing (or not signing) this opt out form;
• By opting out of using my insurance means I must pay out of pocket for the counseling sessions;
• I have made my therapist aware that I have voluntarily decided to opt out of using my insurance for counseling sessions even if she/he is in network or out of network;
• I have agreed to let my therapist know if anything changes and I either obtain alternative insurance and/or decide that I would like my sessions billed to my insurance;
• I understand that if I opt out of using my insurance I cannot use the payment of sessions towards my deductible nor will my therapist provide "Super Bills" for reimbursement purposes because I have elected to opt out of using my insurance;
• That this agreement is in effect from the date I have signed, until I voluntarily elect to make changes and use my insurance;
• If I elect to voluntarily use my insurance in the future that my therapist reserves the right to not allow me to opt out of using my insurance again;
• I understand I cannot opt out of services individually (i.e., I want to opt out of insurance for video sessions but not for in-person sessions) and that by opting out, I am opting out of entirely using my insurance for all services;
• If I choose to later use my insurance my therapist is not liable and is not obligated to reimburse previous sessions where I have chosen to opt out of billing my insurance; and
• If I choose to later use my insurance my therapist, my opting back into use insurance will start from the day I notify my therapist in writing of the change and cannot be backdated to previous sessions. By signing, I acknowledge I have read the Bloom Women's Wellness Insurance Opt Out Form and have been given an opportunity to ask questions and it has been verbally explained the risks and benefits of signing the Insurance Opt Out form. By signing, I am agreeing I have read, understood, and agree to the items contained in Bloom Women's Wellness Insurance Opt Out Form.

| Name Printed | Signature | Date |
|---|---|---|

BLOOM WOMEN'S WELLNESS

# HIPAA Notice of Privacy Practices

HIPAA NOTICE OF PRIVACY PRACTICES
[EFFECTIVE AUGUST 24, 2024]
Note: If you have questions about this Notice, please contact Bloom Women's Wellness. We may be contacted at: 515-499-4959. lf you have questions regarding your clinical records, please call the number listed below.

WHO WILL FOLLOW THIS NOTICE:
This notice describes the privacy practices of Bloom Women's Wellness
Bloom Women's Wellness: 515-499-4959
All providers of Bloom Women's Wellness as well as any health care professional who is authorized to enter information into your chart may have access to information in your chart for treatment, payment and health care operations, and may use and disclose information as described in this Notice. This Notice also applies to any volunteer or trainee we allow to help you while seeking services from us.

OUR PLEDGE REGARDING MEDICAL INFORMATION
Your medical information includes information about your physical and mental health. We understand that information about your physical and mental health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at Bloom Women's Wellness. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by us. This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We reserve the right to revise or amend our Notice of Privacy Practices without additional notice to you. Any revision or amendment of this Notice will be effective for all of your records we have created or maintained in the past, and for any of your records we may create or maintain in the future. We will post a copy of our current Notice and any amended Notice on our public website and keep a paper copy at Bloom Women's Wellness.

OUR OBLIGATIONS TO YOU
We are required by law to:
Make sure that medical information that identifies you is kept private except as otherwise provided by state or federal law; Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:
Bloom Women's Wellness continues to follow disclosure procedures in adherence to Iowa Code Chapter 228 Disclosure of Mental Health and Psychological Information. Iowa law is more stringent regarding disclosure of protected health information and therefore takes precedence over the federal procedures.
The following categories describe different ways that we may use and disclose medical information about you without your consent or authorization. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. The Notice covers treatment, payment, and what are called health care operations, as discussed below. It also covers other uses and disclosures for which a consent or authorization are not necessary. Where Iowa law is more protective of your medical information, we will follow state law, as explained below:

For Treatment: Once you have signed the acknowledgement provided wit
Acknowledgement of Receipt of Privacy Notice
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

During the course of your treatment, we may refer you to other health care providers such as independent laboratories with which you may not have direct contact These providers are called "indirect treatment providers." "Indirect treatment providers" are required to comply with the privacy requirements of Iowa and federal law and keep your medical information confidential.
For Payment: We may use and disclose medical information about you so that the treatment and services you receive at Bloom Women's Wellness may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment received so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment
Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations,
inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Lawsuits and Administrative Procedures: If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved ln the dispute, but only if efforts have been made to tell you and your attorney about the request or to obtain an order protecting the information requested. In addition, we may disclose medical information, including mental health treatment information, to the opposing party in any lawsuit or administrative proceeding where you have put your physical or mental condition at issue.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official:
In response to a court order, subpoena, warrant, summons or similar process;
To identify or locate a suspect, fugitive, material witness, or missing person;
about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct;
about criminal conduct at Bloom Women's Wellness or its affiliates; and
in emergency circumstances to report a crime; the location of the
crime or victims; or the identity, description or location of the person who committed a crime.
Coroners Medical Examiners and Funeral Directors: We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
Protective Services for the President and Others: We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
For Health Care Operations: We may use and disclose medical information about you for "health care operation," These uses and disclosures are necessary to operate Bloom Women's Wellness and make sure that all of our clients receive quality care.

To Avert a Serious Threat to Health or Safety: We may disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat

To Business Associates: Bloom Women's Wellness will from time to time hire consultants, known as "business associates"; who render services to Bloom Women's Wellness. We may disclose your medical information to such consultants. Business associates are required to maintain and comply with the privacy requirements of state and federal law and keep your medical information confidential Examples of "business associates" are accounting firms that are hired to perform audits of billing and payment information, and computer software vendors who assist Bloom Women's Wellness in maintaining and processing medical information

Military and Veterans: lf you are a member of the armed forces, we may release medical Information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Worker's Compensation: We may release medical information about you for worker's compensation or similar programs, and these program's benefits for work-related injuries or illnesses.

Public Health Risks: We may disclose medical information about you for public health activities. These activities generally include the following:
to prevent or control disease, injury or disability;
to report reactions to medications or problems with products;
to notify people of recalls of products they may be using;
to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease condition;
to notify the appropriate government authority if we believe a patient has been a victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree to when required or authorized by law.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU
You have the following rights regarding medical information we maintain about you:
Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually. this includes medical and billing records, but does not include psychotherapy notes.
To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing at Bloom Women's Wellness, 10574 Justin Drive, Urbandale, IA 50322, 515-499-4959.
If you request a copy of the information, we may charge a reasonable fee for the costs of copying. mailing and/or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Bloom Women's Wellness will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Request Amendment: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Bloom Women's Wellness if the information is contained in our designated record set, which usually includes medical and billing records. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request
We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
Was not created by us, unless the person or entity that created the information is no longer available to make that amendment;

Was not created by us, unless the person or entity that created the information is no longer available to make that amendment;
Is not part of the medical information kept by Bloom Women's Wellness or its affiliates;
Is not part of the information which you would be permitted to inspect and copy; or
Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you that are not disclosures for treatment, payment and health care operations.

To request this list or accounting of disclosures, you must submit your request in writing to Bloom Women's Wellness. Your request must state a time period, which may not be longer than six years. Your request will be provided to you on paper. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the mental health treatment or other medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you may request that your spouse or child who is involved in your care not receive certain information about your condition.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
To request restrictions, you must make your request in writing to Bloom Women's Wellness. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosure to your spouse.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Bloom Women's Wellness. We will not ask the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

To obtain a paper copy of this Notice contact Bloom Women's Wellness at 10574 Justin Drive, Urbandale, IA 50322 or call 515-499-4959.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with Bloom Women's Wellness or any of its affiliates or with the Secretary of the Department of Health and Human Services. To file a complaint with Bloom Women's Wellness at 515-499-4959. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosure of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission as set out in an authorization signed by you. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you

Acknowledgement of Receipt of Privacy Notice
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

| _____ | _____ | _____ |
|---|---|---|
| Name Printed | Signature | Date |