

# Center for Emotional Fitness and Shore Therapy

This form is used **both** for an adult patient or child patient to fill out about **himself/herself**. It is also used by a parent, friend, teacher or guardian who needs to **ask** a child all of these questions who will not/cannot fill out form. Any child should bring 2-3 completed forms to the evaluation: One by/about the child and one by **each** parent.

NAME OF PERSON THIS FORM IS ABOUT: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

1. What kind of symptoms are you having (or why are you here)? \_\_\_\_\_

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

2. When did you first notice these symptoms? \_\_\_\_\_

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

3. What is the most important thing you want help with? \_\_\_\_\_

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

4. List all the medications you are supposed to take. (Medical or psychiatric) Include dosages and directions. Please list the effects these medications have on you. Please note if the medications are taken or not

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

5. Are you opposed to medications for yourself or your family member? YES NO

6. Please list all medications taken in the past that helped \_\_\_\_\_

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

7. Are you allergic to any medications? YES NO

8. Please list all medications taken in the past that caused a bad reaction or did not help. Please explain. Any medication may cause a side effect.

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

9. Is there anyone in your family with any type of mental illness or psychiatric problems? YES NO

Who and what (diagnosed or undiagnosed) including parents, brothers, sisters, children, aunts, uncles, nephews, nieces & cousins

10. Is there any family history of drug or alcohol problems? (Diagnosed or undiagnosed) [Including parents, brothers, sisters, children, aunts, uncles, nephews, nieces & cousins] YES NO

11. Have you ever had a psychiatric hospitalization? YES NO If so where? Please give details.

12. Are you now or have you ever been in psychiatric treatment? YES NO If so where? Please give details.

13. Are you now or have you ever been in psychotherapy or counseling? YES NO If so where? Please give details

14. How did prior treatments help or hurt you?

15. Have you ever been diagnosed with any specific medical problems? YES NO If so what? (Past and present)

16. Have you ever had any of the following? PMS Migraines TMJ Fibromyalgia Seizure Cancer Memory Loss  
Problems with: Brain; muscles; nerves; Heart; Lungs; Kidney; Thyroid; Stomach/intestines; Endocrine; Aches/pains

17. Do you smoke cigarettes, cigars or chew tobacco? YES NO If so, which and how much? \_\_\_/day

18. Do you drink alcohol? YES NO If so, what do you drink? How much? \_\_\_/day \_\_\_/week

Did you ever have a drinking problem? YES NO If so, how much were you drinking at the time? \_\_\_/day/week

When did you stop? \_\_\_\_\_

19. Have you ever felt that you should cut down your drinking? YES NO

20. Has anyone ever criticized your drinking? YES NO

21. Have you ever felt bad or guilty about drinking? YES NO

22. Have you ever taken a drink 1<sup>st</sup> thing in the morning

to steady your nerves or get rid of a hangover? YES NO

23. Do you gamble? (Atlantic City, football pool, bingo, lottery, etc.) YES NO

If so do you have gambling debts? YES NO How much now? \_\_\_\_\_What is the most you ever lost? \_\_\_\_\_

24. Have you ever been in a motor vehicle accident? YES NO Please give details. \_\_\_\_\_

25. Have you ever had a head injury before? Were you unconscious? YES NO If so please explain in detail. \_\_\_\_\_

26. Have you had any other accidents (an assault, slip and fall, athletic, etc.) major or minor? YES NO

Please give details. How did it affect your life? \_\_\_\_\_

27. Did you ever use street drugs? YES NO Which ones? \_\_\_\_\_

A/ How did they affect you? \_\_\_\_\_

B/ What is your drug(s) of choice \_\_\_\_\_

C/ Do you use drugs now? YES NO \_\_\_\_\_ When did you last use? \_\_\_\_\_

28. How much caffeine do you consume in a day? (Coffee, tea, soda, energy drinks, etc.)

29. Have you ever been in trouble with the law? (Juvenile or adult) YES NO

Please explain \_\_\_\_\_

30. What are your strengths? \_\_\_\_\_

31. What are your weaknesses? \_\_\_\_\_

32. How do you spend your average day?

33. What has been going on in your life in the past few months? \_\_\_\_\_

34. What kind of work do you do? \_\_\_\_\_ Are you happy in this employ? YES NO

What kinds of jobs have you held in the past \_\_\_\_\_

35. Have you ever had surgery? YES NO If yes, what kind? \_\_\_\_\_

36. Have you ever been raped, molested, or physically or mentally abused? YES NO Please explain. \_\_\_\_\_

37. Do you like yourself? YES NO \_\_\_\_\_

38. Do you have a pet? YES NO What is your relationship with your pet? \_\_\_\_\_

39. What is the earliest memory of your childhood? \_\_\_\_\_

40. Tell me about your childhood, including school problems. \_\_\_\_\_

41. Tell me about your adolescence, including school problems. \_\_\_\_\_

42. Tell me about your adulthood. \_\_\_\_\_

43. What is your relationship with your:  
 Mother: \_\_\_\_\_  
 Father: \_\_\_\_\_  
 Brother(s)/Sister(s): \_\_\_\_\_  
 Friends: \_\_\_\_\_  
 Spouse: \_\_\_\_\_  
 Children: \_\_\_\_\_

44. What sacrifices, if any, have you made for these people? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

45. What sacrifices, if any, have they made for you? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

46. Who do you live with? \_\_\_\_\_

47. Are there locks on your bathroom doors? YES NO Do people see each other naked in your home? YES NO

48. How did your parents' relationship affect you when you were younger? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

49. How has it affected you through the years? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

50. Do you have a best friend? YES NO Who is it and why? \_\_\_\_\_

51. How many years of schooling have you had? \_\_\_\_\_

52. Did you have any problem with school? Did anyone think that you had a learning disability? Were you classified in school? Were you in special education? \_\_\_\_\_

53. Do you have any problem with your interest in sexual relations, your performance sexually or your ability to achieve orgasms? Do you have an active sex life? Please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

54. Are you crying for no reason? YES NO Please describe: \_\_\_\_\_  
 \_\_\_\_\_

55. Are you in physical pain? NO PAIN MILD PAIN MODERATE SEVERE PAIN EXCRUCIATING PAIN  
 i i i i i  
 0 1 2 3 4 5 6 7 8 9 10

56. What is the best thing that ever happened to you? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

57. What is the worst thing that ever happened to you? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

58. Have you ever had a seizure? YES NO Explain: \_\_\_\_\_

59. Have you ever had an imaginary friend? YES NO Explain: \_\_\_\_\_

60. Do you snore? YES NO Do you stop breathing when you snore? YES NO

61. a. Do you wash your hands a lot, clean a lot or check things a lot? YES NO

b. Do you think/worry a lot about things that make no sense YES NO

c. Do your daily activities take a long time to finish YES NO

62. a. Are there any thoughts that keeps bothering you that you want to get rid of, but can't? YES NO

b. Are you concerned about orderliness or symmetry? YES NO

63. Do you do things you don't remember doing? YES NO

Do people tell you have done things that you are sure you haven't done? YES NO \_\_\_\_\_

64. What did you eat in the last 24 hours? \_\_\_\_\_

65. How do you feel about exercise? What do you do for exercise? \_\_\_\_\_

66. How do you feel about your looks? \_\_\_\_\_

67. Do you have access to a gun? YES NO

68. Have you ever engaged in high risk behavior or thrill seeking that has a high potential for consequences (such as spending sprees, sexual indiscretion or promiscuity, foolish business investments or drug or alcohol abuse)? YES NO

Explain: \_\_\_\_\_

69. Are you religious? YES NO Please explain: \_\_\_\_\_

70. Do you have trouble falling asleep or trouble staying asleep because you have the urge to move your legs? YES NO

71. Have you ever felt very depressed? YES NO Now YES/NO Before the age of 20? YES/NO Before age 12? YES/NO

Please explain: \_\_\_\_\_

72. Do you feel suicidal now? YES NO Please explain: \_\_\_\_\_

73. Have you ever felt suicidal? YES NO Please explain: \_\_\_\_\_

74. Have you ever tried to kill yourself or purposely injured yourself or started to hurt, kill, or injure yourself? YES NO

Please explain \_\_\_\_\_

75. Do you often feel nervous, edgy, anxious, jittery, stressed out, concerned, worried, "what if this, what if that," even if you have a good reason to feel this way? YES NO Do you spend time thinking about the worst thing that could happen?

Please explain: \_\_\_\_\_

76. Have you ever felt nervous, edgy, anxious, jittery, stressed out, concerned, worried, "what if this, what if that," or spent a lot of time thinking about the worst thing that could happen even if you had a good reason to feel this way?

Please explain: \_\_\_\_\_

77. Do you or have you ever seen things that other people don't see? YES NO

Please explain: \_\_\_\_\_

78. Do you hear or have you ever heard voices when no one is in the room? YES NO

Please explain: \_\_\_\_\_

79. Has your mind ever played tricks on you? YES NO

Please explain: \_\_\_\_\_

80. Has your brain ever held a conversation over which you had no control? YES NO

Please explain: \_\_\_\_\_

Can people put thoughts into your head or take thoughts out? YES NO

Please explain \_\_\_\_\_

Can people read your mind or can you read their minds? YES NO

Please explain \_\_\_\_\_

81. Is anyone trying to hurt or harm you now or in the past? YES NO

Please explain \_\_\_\_\_

82. Do you have nightmares? YES NO

Please explain \_\_\_\_\_

83. Do you now or have you ever, ever, ever™ felt too happy? YES NO

Please explain \_\_\_\_\_

84. Do you now or have you ever, ever, ever™ felt too giddy, too elated or too full of? YES NO

Please explain \_\_\_\_\_

85. Do you now or have you ever, ever, ever™ felt too angry? YES NO

Please explain \_\_\_\_\_

86. Do you now or have you ever felt too sexy? YES NO Please explain \_\_\_\_\_

87. Do you have any habits such as twitches, eye blinks, coughing, clearing your throat or any other rituals over which you have little or no control? YES NO

Please explain \_\_\_\_\_

88. Do you now or have you ever had racing thoughts (thoughts racing so fast in your head that you can't keep up with them)? YES NO Please explain \_\_\_\_\_

89. Are you a procrastinator? YES NO Please explain \_\_\_\_\_

90. Do you now or have you ever felt that people are against you? Do you now or have you ever felt paranoid? YES NO Please explain \_\_\_\_\_

91. Do people consider you disagreeable? YES NO Do you consider yourself disagreeable? YES NO

92. Do people consider you irritable? YES NO Do you consider yourself irritable? YES NO

93. Do people consider you impatient? YES NO Do you consider yourself impatient? YES NO

94. Do people consider you argumentative? YES NO Do you consider yourself argumentative? YES NO

95. Do people consider you angry? YES NO Do you consider yourself angry? YES NO

96. Are your moods predictable, for instance, when you go to bed at night do you know what mood you will be in when you wake up in the morning because your moods are always the same? YES NO Please explain \_\_\_\_\_

**97. ADHD checklist. (Attention-Deficit/Hyperactivity Disorder) Do you have the following now or did you as a child?**

- Now  In the past  Never  Always 1. Often fail to give close attention to details or make careless mistakes in schoolwork, work or other activities
- Now  In the past  Never  Always 2. Often have difficulty sustaining attention in tasks or play activities
- Now  In the past  Never  Always 3. Often do not seem to listen when spoken to directly
- Now  In the past  Never  Always 4. Often do not follow through on instructions and fails to finish schoolwork, chores, or duties
- Now  In the past  Never  Always 5. Often have difficulty organizing tasks and activities
- Now  In the past  Never  Always 6. Often avoid, dislike or are reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- Now  In the past  Never  Always 7. Often lose things for tasks or activities (e.g., toys, school assignments, pencils, books tools)
- Now  In the past  Never  Always 8. Often easily distracted by extraneous stimuli (sounds, smells, lights, activity)
- Now  In the past  Never  Always 9. Often forgetful in daily activities (although these things are done over and over again)
- Now  In the past  Never  Always 10. Often fidget with hands or feet or squirm in seat
- Now  In the past  Never  Always 11. Often leave seat in classroom or other situations in which remaining seated is expected
- Now  In the past  Never  Always 12. Often run about or climb excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- Now  In the past  Never  Always 13. Often have difficulty playing or engaging in leisure activities quietly
- Now  In the past  Never  Always 14. Often "on the go" or often act as if "driven by a motor"
- Now  In the past  Never  Always 15. Often talk excessively (talks too much; trouble getting to the point)
- Now  In the past  Never  Always 16. Often blurt out answers before questions have been completed
- Now  In the past  Never  Always 17. Often have difficulty awaiting turn
- Now  In the past  Never  Always 18. Often interrupt or intrude on others (e.g., butt into conversations or games)

**98. SPIN (SOCIAL PHOBIA INVENTORY)**

	Not at all	A little bit	Somewhat	Very much	Extremely
	0	1	2	3	4
1. I am afraid of people in authority.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I am bothered by blushing in front of people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Parties and social events scare me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I avoid talking to people I don't know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Being criticized scares me a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Fear of embarrassment cause me to avoid doing things or speaking to people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Sweating in front of people causes me distress.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I avoid going to parties.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I avoid activities in which I am the center of attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Talking to strangers scares me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I avoid having to give speeches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I would do anything to avoid being criticized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Heart palpitations bother me when I am around people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I am afraid of doing things when people might be watching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Being embarrassed/looking stupid are among my worse fears.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I avoid speaking to anyone in authority	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Trembling or shaking in front of others is distressing to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**PLEASE ADD UP YOUR TOTAL SCORE \_\_\_\_\_**

**99. PANIC ATTACK AND ANXIETY ATTACK QUESTIONAIRE**

- 1. Do you have panic attacks or anxiety attacks out of the blue? YES NO
- 2. Do they develop abruptly and reach a peak in within 10 minutes? YES NO
- 3. Do you have the following symptoms with these attacks (check all that apply)?
  - Shortness of breath/smothering sensations  Sweating
  - Unreality feelings (Derealization or Depersonalization)  Chills or hot flushes
  - Dying is feared  Abdominal distress or nausea
  - Discomfort in the chest or chest pain  Rapid heart beat, palpitations or pounding heart
  - Evidence of trembling or shaking  You feel you are choking
  - Numbness or tingling sensations (paresthesia)
  - Lightheaded, dizzy, unsteady or faint  You fear you are losing control or going crazy

**100. CIRCLE BELOW - ⓪ - how often you have had each symptom over the last 7 days**

0% is not even once over the last 7 days; 1-19% is rarely; 20 -39% is more than rarely but less than half; 40-59% is half the time last week  
60 -79% is more than 1/2 but less than most; 80 -99% is most but not all the time over the last 7 days; 100% is all the time the last 7days

Depressed / sad / tearful / empty	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Interest is low / loss of pleasure in things	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Sleep disturbance	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Guilty or worthless	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Unusually slow or quick moving vs. normal	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Suicidal thoughts, ideas, acts or focus	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Thinking / concentration / attention problems	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Energy is low	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Decreased or increased appetite	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Loss of motivation, drive, ambition, initiative	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Anxiety/worry/fear/nervous/stress/ "what ifs"	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Angry / irritable / disagreeable / bitchy	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Pain	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Too happy / elated / excited / too full of self	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
More distracted than usual	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Racing thoughts or flight of ideas	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Talking more or faster than usual	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
High activity level / cannot sit still / interrupting	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Sleeping very little but not feeling tired	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Inflated self-esteem or grandiosity	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Engaging in dangerous/expensive/foolishness	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Hallucinations-seeing or hearing things not there	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Paranoia / suspiciousness / delusions	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Panic / Panic attacks / Anxiety attacks	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Shyness / Fear of embarrassment socially	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Counting / checking / washing / ordering /OCD	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Muscle Tension / Muscle Tightness	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%								
Cigarette smoking daily	0	1 to 5	6 to 10	11 to 15	16 to 20	21 to 30	31+								
Alcohol Use over last week. Number of drinks	0	1 to 5	6 to 10	11 to 15	16 to 20	21 to 30	31+								
Happy - Sad Scale (Please circle from +6 to -6)	happiest ever+6	+5	+4	+3	+2	+1	0	-1	-2	-3	-4	-5	-6	saddest ever	
Overall functioning (Please circle from +6 to -6)	best ever	+6	+5	+4	+3	+2	+1	0	-1	-2	-3	-4	-5	-6	worst ever
How would you rate your depression this week?	None	Mild	Mild-Moderate	Moderate	Moderate-Severe	Severe	Extreme								



# **HIPAA NOTICE OF PRIVACY PRACTICES**

Effective Date: April 14, 2003

**Center for Emotional Fitness  
One Utah Avenue  
Cherry Hill, NJ 08002**

**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.**

**This Notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementing regulations (“HIPAA”). It is designed to tell you how we may, under federal law, use or disclose your Health Information.**

- I. We may Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each:**
  - We may provide your Health Information to health care professionals-including doctors, nurses and technicians for purposes of providing you with care.
  - Our billing department may access your information and send relevant parts to the other insurance companies to allow us to be paid for the services we render to you.
  - We may access or send your information to our attorneys or accountants in the event we need the information in order to address our own business functions.
  
- II. We May Also Use or Disclose Your Health Information Under the Following Circumstances without Obtaining Your Prior Authorization:**
  - To Notify and/or Communicate with your Family.** Unless you tell us you object, we may use or disclose your Health Information in order to notify your family or assist in notifying your family, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in any communications with your family and others.
  - As Required by Law.**
  - For Public Health Purposes:** We may use or disclose your Health Information to provide information to state or federal public health authorities, as required by law to prevent or control disease, injury or disability; to report child abuse or neglect; report domestic; report to the Food and Drug Administration problems with products and reactions to medications; and report disease or infection exposure.
  - For Health Oversight Activities.** We may use or disclose your Health Information to health agencies during the course of audits, investigations, certification and other proceedings.
  - In Response to Subpoenas or for Judicial and Administrative Proceedings.** We may use or disclose your Health Information in the course of any administrative or judicial proceeding. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person.
  - To Law Enforcement Personnel.** We may use or disclose your Health Information to a law enforcement official to identify or locate a suspect, fugitive, material witness or missing person, comply with a court order or subpoena and other law enforcement purposes.
  - To Coroners or Funeral Directors.** We may use or disclose your Health Information for purposes of communicating with coroners, medical examiners and funeral directors.
  - For Purposes of Organ Donation.** We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.
  - For Public Safety.** We may use or disclose your Health Information in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
  - To Aid Specialized Government Functions.** If necessary, we may use or disclose your Health Information for military or national security purposes.
  - For Worker’s Compensation.** We may use or disclose your Health Information as necessary to comply with worker’s compensation laws.
  - To Correctional Institutions or Law Enforcement Officials, if You are an Inmate.**

**III. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization.** If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.

**IV. Your Rights.**

- a. You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with your request.
- b. You have the right to receive your Health Information through confidential means through a reasonable alternative means or at an alternative location.
- c. You have the right to inspect and copy your Health Information. We may charge you a reasonable cost-based fee to cover copying, postage and/or preparation of a summary.
- d. You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.
- e. You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with family; and/or for certain government functions, to name a few.
- f. You have a right to a paper copy of this Notice of Privacy Practices. 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 the Privacy Officer at The Center for Emotional Fitness (856) 857-9500.

**VI. Our Duties.**

- We are required by law to maintain the privacy of your Health Information (and to provide you with a copy of this Notice.)
- We are also required to abide by the terms of this Notice.
- We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all you Health Information-even if it was created prior to the change in the Notice. If such amendment is made, we will immediately display the revised Notice at our office and provide you with a copy of the amended Notice. We will also provide you with a copy, at any time, upon request.

**VII. Complaints to the Government.**

- You may make complaints to the Secretary of the Department of Health and Human Services if you believe your rights have been violated.
- We promise not to retaliate against you for any complaint you make to the government about our privacy practices.

**VIII. Contact Information**

- You may contact us about our privacy practices by calling the Privacy Officer at: (856) 857-9500
- You may contact the DHHS at:  
U.S. Department of Health and Human Services  
200 Independence Ave., S.W.  
Washington, DC 20201  
(877) 696-6775

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

**Signature below is only an acknowledgement that you have received this Notice of our Privacy Practices:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_