PATIENT INFORMATION Date: _____ Provider _____

Full Patient Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone ( )_____ Work Phone ( )_____ Cell ( )_____

Circle Appropriate Description: Male / Female Marital Status: Single / Married / Divorced / Widowed / Separated

Race: White / African American / Hispanic / Asian / Pacific Islander / Other Ethnicity: Non-Hispanic / Hispanic

Birthdate _____ Age _____ Referred By _____ Phone ( )_____

PATIENT EMPLOYER

Employer Name _____ Occupation _____ Full/time Part/time

Address _____ City _____ State _____ Zip _____

IF THE PATIENT IS NOT THE PERSON TO BE BILLED, PLEASE COMPLETE THIS SECTION.

Dependent Person is a: Adult Child Spouse

Student Status: Full-time Part/time School _____ Level/Grade _____

Responsible Party Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Home Phone ( )_____ Work Phone ( )_____ Other ( )_____

CAREGIVER IF OTHER THAN ABOVE: _____
Name Phone

EMERGENCY CONTACT (In case of an emergency or if unable to contact you, whom may we notify or leave a message with:)

Name _____ Relationship _____ Phone ( )_____

Address _____ City _____ State _____ Zip _____

If under 18, legal guardian _____
(name, address, phone number)

INSURANCE **Please keep insurance cards handy as we will want to make a copy for our records.**

Primary Policy

Name of Insured Policyholder _____ Birthdate _____ Social Security # _____

Address if different from patient _____

Insurance Company _____ Policy/ID # _____ Effective Date _____

Is this Managed Care? Yes No Have you contacted your insurance/managed care company? Yes No

If insurance is through an employer:
Employer Name/Address _____Phone ( ) _____

Secondary Policy

Name of Insured Policyholder _____ Birthdate _____ Social Security # _____

Address if different from patient _____

Insurance Company _____ Policy/ID # _____ Effective Date _____

Is this Managed Care? Yes No Have you contacted your insurance/managed care company? Yes No

If insurance is through an employer:
Employer Name/Address _____Phone ( ) _____

PHARMACY INFO:

NAME OF PHARMACY: _____
ADDRESS: _____
TEL #_____
FAX#_____

FOCUS MENTAL HEALTH SOLUTIONS, PLLC

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

_____ _____ _____

Patient's Last Name Patient's First Name Patient's DOB

By signing below, I hereby acknowledge receipt of Focus Mental Health Solutions, PLLC's Notice of Privacy Practices and consent to the uses and disclosures described in the Notice of Privacy Practices.

➡ _____ _____ 2018

Signature of Patient (Legal or Personal Representative) Date

_____ _____ 2018

Signature of Parent/Guardian/Legal or Personal Representative Date

(Please indicate your legal authority to act for this patient) _____

_____ Patient Refuses to Acknowledge Receipt:

_____ _____ 2018

Signature of Staff Member Date

- - - - - - - - - - - - - -

AUTHORIZED PERSONS TO ACCESS MY INFORMATION:

NAME	**ADDRESS**	**PHONE/EMAIL**
1.		
2.		
3.		
4.		
5.		

➡ _____ _____ 2018

Signature of Patient (Legal or Personal Representative) Date

Focus Mental Health Solutions, PLLC

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices

I, _____, (name of patient or legal or personal representative), hereby give my consent to Focus Mental Health Solutions, PLLC, to use or disclose for the purpose of carrying out treatment, payment or healthcare operations, some basic information contained in the patient record of _____.
(Patient's Name)

I understand that by law and professional ethics, what is shared in psychotherapy remains confidential unless permission has been given to share it, or except as the law or my managed care company requires.

I consent to the release of basic identifying information and the amount of the unpaid balance to a collection service or an attorney for purposes of collecting a debt if this becomes necessary.

I understand and consent to the release of information about my condition and care (including access to my chart) to the managed care company for their review for purposes of payment or quality assessment. If seeing a therapist as opposed to a Psychiatrist, I understand that some insurance companies require the therapist be supervised by a Psychiatrist. I understand the supervision will involve a review of the treatment plan and confidential discussion of my progress.

I understand and consent to the release of information about my condition and care (including access to my chart) to all the providers, both doctors and therapists, of FMHS. I understand that they provide on-call coverage for each other as well as for continuity of care should I see multiple providers within FMHS.

I acknowledge receipt of Focus Mental Health Solutions, PLLC's Notice of Privacy Practices and consent to the uses and disclosures therein.

I understand that Focus Mental Health Solution reserves the right to change the privacy practices described and that a copy of any Revised Notice will be made available to me at my next visit.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent by giving written notice of my desire to do so to my provider. I also understand that I will not be able to revoke this consent in cases where the provider has relied on it to disclose my health information.

Signed: _____ _____ Date: _____

By signature below, I consent and understand that a courtesy letter will be sent to my primary/healthcare physician to aid in the continuity of my care.

Primary Care Physician: _____ Phone:_____ _____

Practice Name: _____

Address: _____

Signed: _____ Date: _____

*If you have no primary care physician or do not wish to disclose this information to your primary care physician, please sign here.

_____

Focus Mental Health Solutions, PLLC Consent for Treatment & Financial Policy

TREATMENT

You and your clinician will work together to identify treatment goals and options. The length of time in treatment will vary according to individual needs and will be discussed throughout the course of your care. You are encouraged to talk as openly as possible about the problems you are experiencing so that your clinician can better assist you in treatment planning. Your clinician will inform you about treatment options and will include potential benefits and risks associated with those options. You do have the right to refuse treatment. As mental health treatment is an inexact science, no guarantees can be made as to the success of such treatment.

PAYMENT POLICIES

We accept cash, personal checks, debit cards, MasterCard, Visa, American Express and Discover. Payment of copays and deductibles are due at the time of service.

Focus Mental Health Solutions, PLLC schedules appointments by a block of time for each patient. If you are unable to attend your scheduled appointment, we reserve the right to charge the full office fee for any late notice cancellations or missed appointments. Your insurance will generally not cover this charge. If you have any questions regarding this policy, please discuss them with your clinician.

As insurance is a contract between you and your insurance carrier, you are ultimately responsible for payment of all charges. You must provide proof of insurance at the time of your initial visit and are responsible for providing this office with changes in insurance coverage. Failure to do so may result in denial of your claim. As a matter of courtesy to our patients, we will submit charges to your insurance company. Any amount that your insurance company will not be paying such as a co-pay or deductible is due from you at the time service is rendered. If your insurance company has not paid within sixty days or denies coverage, the balance will be billed to you for immediate payment**. If you do not have insurance, payment in full is required at the time of service.** If there are any problems with meeting your financial obligations, please speak with your clinician.

Some managed care companies require the patient to get **PRIOR** approval and an authorization for their visit. If you fail to get necessary prior approval for your visit, payment in full is required at the time of service.

If a patient's bill remains unpaid, Focus Mental Health Solutions, PLLC reserves the right to provide your name, basic identifying information and the amount of the unpaid balance to collection services or an attorney.

ASSIGNMENT OF BENEFITS

Insurance Authorization/Release: By signature below, I hereby authorize Focus Mental Health Solutions, PLLC to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company; to pursue rightful collection of monies owed by my insurance company for services rendered until the company's responsibility has been satisfied or all appeal efforts have been exhausted and thereby authorize payment of the insurance benefits directly to Focus Mental Health Solutions, PLLC for any and all services rendered.

Medicare Authorization/Release: By signature below, I request that payment of authorized Medicare benefits be made on my behalf to Focus Mental Health Solutions, PLLC for any and all services rendered to me by their providers. I hereby authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

My signature below indicates that I have read and understand the foregoing information relative to my responsibility for the services provided as well as authorizing the release of medical information as required to process claims and benefits to which I am entitled.

Patient Signature  _____ Date: _____

Patient Name Printed: _____ DOB: _____

On behalf of a minor child or guardian:
Responsible Party: _____ Date: _____

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH AND/OR ALCOHOL AND DRUG ABUSE INFORMATION

Name of Patient: _____DOB: _____

Address: _____

I (We) hereby authorize

Focus Mental Health Solutions, PLLC
3016 W. Charleston Blvd, Suite 150
Las Vegas, NV 89102

Ph: 702-790-2701
Fax. 702-790-2706

To ☐ **Release** ☐ **Exchange** ☐ **Receive** records or information as requested below:

Agency/Person to release/receive: _____

Address: _____

_____

Specific Nature of Information to be disclosed – Please initial or place check mark by each requested item:

_____ Initial Psychiatric History/Evaluation
_____ Psychological Reports/Evaluations
_____ Lab/X-ray/Test Results
_____ Consultations
_____ Other _____

_____ Progress Notes
_____ Complete Medical Record
_____ Financial Information
_____ Contact/Discuss Treatment and Progress
_____ All information

For the purpose of: (Please check all that apply)

_____ Continuing (mental health/alcohol or drug abuse) treatment, care and continuity of care
_____ Therapist transition
_____ Other_____

_____ Billing and payment related matters
_____ Legal

This consent is **valid for one year from date signed** (unless otherwise specified). Other Date: _____
I understand that I may revoke this authorization by notifying Focus Mental Health Solutions, PLLC at 3016 W Charleston Blvd, Suite 150, Las Vegas, NV 89102, in writing of my desire to revoke release prior to its expiration except to the extent that action has already been taken by FMHS in reliance on the consent.

I understand that FMHS **may not condition treatment** or quality of care upon completion of this form. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization which will **prevent disclosure of information.**

I understand that FMHS may, directly or indirectly, receive remuneration from another party in connection with the use or release of disclosed health information. I understand that I also will be charged for review and copying of records.

I understand that the information disclosed may be subject to re-disclosure by the person(s) receiving it and will no longer be protected by the federal privacy regulations.

I have read and understand the terms of this authorization and release and have had an opportunity to ask questions about the use and disclosure of my health information. By signature, I knowingly and voluntarily authorize FMHS to use or disclose my health information in the manner described above.

_____/_____ _____/_____
Patient Signature Date Witness Date

_____/_____ _____/_____
Parent/Legal Guardian Signature Date Witness Date

NOTICE TO PATIENT AND RECEIVING AGENCY:
Under the provisions of the Mental Health and Developmental Disabilities Confidentiality Act and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be disclosure of any of the information provided pursuant to this release unless the patient and/or parent of the patient specifically authorizes such disclosure.

FOCUS MENTAL SOLUTIONS, PLLC

AUTHORIZATION FOR APPOINTMENT REMINDER SERVICE

Name of Patient _____ DOB _____

Address _____

I hereby authorize Focus Mental Health Solutions, PLLC, to contact the below telephone number OR email address in order to remind me of upcoming appointments.

PLEASE CHECK ONE:

☐ Telephone: _____

☐ Email: _____

☐ I elect NOT to receive an appointment reminder

If the above number/address changes, I understand that it is my responsibility to contact Focus Mental Health Solutions, PLLC and change my information so it does not get delivered to an unauthorized party.

Focus Mental Health Solutions, PLLC schedules appointments by a block of time for each patient**. If you are unable to attend your scheduled appointment, we reserve the right to charge $50.00 fee for any late notice cancellations or missed appointments.** Your insurance will not cover this charge. If you have any questions regarding this policy, please discuss them with your clinician.

I understand that only information regarding my future appointments will be delivered, and that my information will not be given to any third party.

➡_____/_____ _____/_____

Patient Signature Date Witness Signature Date

_____/_____

Guardian Signature Date

MEDICATION REFILL POLICY

Initial: _____• It is your responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three (3) business days so please be courteous and do not wait to call. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.

Initial: _____• Medication refills will only be addressed during these office hours (Monday-Thursday 8am-4pm). Focus Medical Staff will not return any phone calls regarding refills, refill requests will only be accepted by a medication refill request from your pharmacy. Please notify your provider on the next business day if you find yourself out of medication after hours. No prescriptions will be refilled on Saturday, Sunday or Holidays.

Initial: _____• Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.

Initial: _____• Some medications require prior authorization. Depending on your insurance this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guaranty that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.

Initial: _____• It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills. All prescriptions require a follow up appointment every 3 to 6 months.

Initial: _____• If you have any questions regarding medications please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed please contact us immediately.

Initial: _____• New symptoms or events require a clinic appointment. Your provider will not diagnose or treat over the phone.

Print Name: _____

Signature: _____**Date:** _____

3016 West Charleston Boulevard, Suite 150 Las Vegas, NV 89102, Phone: 702-790-2701, Fax: 702-790-2706

Patient Rights & Responsibilities

- Patients have the right to be treated with personal dignity and respect.

- Patients have the right to care that is considerate and respects member's personal values and belief system.

- Patients have the right to personal privacy and confidentiality of information.

- Patients have the right to receive information about managed care company's services, practitioners, clinical guidelines, and patient rights and responsibilities.

- Patients have the right to reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.

- Patients have the right to participate in an informed way in the decision making process regarding their treatment planning.

- Patients have the right to discuss with their providers the medically necessary treatment options for their condition regardless of cost or benefit coverage.

- Patients have the right of members' families to participate in treatment planning as well as the right of members over 12 years old to participate in such planning.

- Patients have the right to individualized treatment, including
    - Adequate and humane services regardless of the source(s) of financial support,
    - Provision of services within the least restrictive environment possible,
    - An individualized treatment or program plan,
    - Periodic review of the treatment or program plan, and
    - An adequate number of competent, qualified, and experienced professional clinical staff to supervise and carry out the treatment or program plan.

- Patients have the right to participate in the consideration of ethical issues that arise in the provision of care and services, including
    - Resolving conflict,
    - Withholding resuscitative services,
    - Forgoing or withdrawing life-sustaining treatment, and
    - Participating in investigational studies or clinical trials.

- Patients have the right to designate a surrogate decision-maker if the member is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care.

- Patients and their families have the right to be informed of their rights in a language they understand.

- Patients have the right to voice complaints or appeals about managed care company or the care provider.

- Patients have the right to make recommendations regarding managed care company rights and responsibilities policies.

- Patients have the right to be informed of rules and regulations concerning patients' conduct.

- Patients have the responsibility to give their provider and managed care company information needed in order to receive care.

- Patients have the responsibility to follow their agreed upon treatment plan and instructions for care.

- Patients have the responsibility to participate, to the degree possible, in understanding their behavioral health problems and developing with the provider mutually agreed upon treatment goals.

FOCUS MENTAL HEALTH SOLUTIONS, PLLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes the privacy practices of Focus Mental Health Solutions, PLLC (FMHS) and all business associates with whom we may share your protected health and medical information.

We understand that your medical or PHI ("protected health information") is confidential and we are committed to maintaining its privacy. Federal law requires that we provide you with this Notice of our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this Notice when we use or disclose your PHI and are also required by law to notify you if you are affected by a breach of your secured PHI.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION OR PHI ABOUT YOU

Treatment Purposes. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. In addition, we may contact individuals through telephone, mail and email with appointment reminders and may utilize facsimile transmissions for specific authorizations and prescription refills through pharmacies. We may also disclose your PHI to other providers involved in your treatment.

Payment Purposes. We may use and disclose PHI to obtain payment for the treatment services provided. For example, we send PHI to Medicare, Medicaid, your health insurer, HMO, or other company or program that is to pay for your health care so they can determine if they should pay the claim. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

Health Care Operations. We may also disclose PHI to other health care providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, and peer review. We may share your PHI with third parties that perform various business activities such as an outside billing company, appointment reminder service or electronic practice management vendor provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.

Disclosure to Family, Close Friends and Other Caregivers. In an emergency situation, we may disclose PHI to those involved in a patient's care when the patient approves or, when the patient is not present or not able to approve, when such disclosure is deemed appropriate in the professional judgment of the practice or such as necessary. When the patient is not present, we determine whether the law requires the disclosure of the patient's PHI, and if so, disclose only the information directly relevant to the person's involvement with the patient's health care.

Disclosures Required by Law. As a behavioral health provider, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. However, we may also use or disclose PHI about you without your prior authorization, subject to certain requirements and **as required by law.**

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public**.** If PHI is disclosed for this reason, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat. We may disclose PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Health Oversight Activities. We may use and disclose your PHI to state agencies and federal government authorities when required and as authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control. We may use and disclose your PHI in order to assist others in determining your eligibility for public benefit programs and to coordinate delivery of those programs.

Judicial and Administrative Proceedings. We may use and disclose your PHI in judicial and administrative proceedings such as pursuant to a subpoena, court order, administrative order or similar process. Efforts may be made to contact you prior to a disclosure of your PHI to the party seeking the information.

Law Enforcement. We may use or disclose PHI to law enforcement to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

Specialized Government Functions. We may review requests from US military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Dept of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Work-Related Injuries. We may use or disclose PHI to an employer to evaluate work-related injuries.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm or to provide treatment in an emergency situation. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Uses and Disclosures Required by Law – DO NOT APPLY TO PRACTICE. We may disclose information as required by law for the following purposes although generally these do not apply to AIMH: **marketing and research studies; fundraising; coroner or medical examiner and funeral directors for death certificate; disclosures to facilitate organ, eye and tissue donations.**

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

For any purpose other than the ones described above, we will only use or disclose your PHI when you give us your written authorization. For instance, we will obtain your written authorization before we send your PHI to your employer or health plan sponsor, for underwriting and related purposes for a life insurance company or to the attorney representing the other party in litigation in which you are involved.

Highly Confidential Information. Federal and Illinois law requires special privacy protections for highly confidential information about you. Highly Confidential Information consists of PHI related to: psychotherapy notes; mental health and developmental disabilities services; alcohol and drug abuse services; HIV/AIDS testing, diagnosis or treatment; venereal disease(s); genetic testing; child abuse and neglect; domestic abuse of an adult with a disability; or sexual assault. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

YOUR RIGHTS REGARDING YOUR PHI

Right to Receive an Accounting of Disclosures. You have the right to request an accounting of disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or release made pursuant to your authorization. If you request an accounting more than once during a twelve (12) month period, we will charge you $25. A request for disclosures must be made in writing to the Privacy Officer.

Right to Inspect and Copy Your PHI. You have a right to inspect or get a copy of your medical record file and billing records maintained by us. In some circumstances, we may deny you access to a portion of your records. If you desire access to your records, submit your request in writing to the Privacy Officer. A reasonable fee, not to exceed limits allowed under Illinois law, will be charged for the copying and mailing.

Right to Amend Your Records. You have the right to request that we amend PHI maintained in your medical record file or billing records. If you desire to amend your records, please submit your request in writing to the Privacy Officer. We are not required to agree with your request to amend.

Right to Request Restriction of Disclosures. You may submit a request in writing to the Privacy Officer to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

Right to Receive Confidential Communications. We accommodate all reasonable requests to keep communications confidential and to allow you to receive your PHI by alternative means of communication or at alternative locations. A request for confidential communications must be in writing, must specify an alternative address or other method of contact and must provide information about how payment will be handled. The request should be submitted to the Privacy Officer. We will determine the reasonableness based on the administrative difficulty of complying with the request. We will reject a request due to administrative difficulty if no independently verifiable method of communication (such as a mailing address or published telephone number) is provided for communications; or if the requestor has not provided information as to how payment will be handled.

Authorization. We obtain written authorization from a patient or a patient's representative for the use or disclosure of PHI for reasons other than treatment, payment or health care operations. We will not, however, get an authorization for the use or disclosure of PHI specifically allowed under the Privacy Rule in the absence of an authorization. We do not condition treatment of a patient on the signing of an authorization, except disclosure necessary to determine payment of claim (excluding authorization for use or disclosure of psychotherapy notes); or provision of health care solely for the purpose of creating PHI for disclosure to a third party (pre-employment or life insurance exams). A specific written authorization is required to disclose or release mental health treatment notes, alcoholism treatment, drug abuse treatment or HIV/Acquired Immune Deficiency Syndrome (AIDS) information.

Right to Revoke Your Authorization. You have the right to revoke your written authorization, except to the extent that we have taken action in reliance upon it, by submitting your request in writing to the Privacy Officer.

Effective Date and Changes to this Notice. This Notice is effective May 01, 2017. We reserve the right to revise this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new Notice. Any new Notice will be posted in the reception area of Focus Mental Health Solutions, PLLC

Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of the breach, including what happened and what you can do to protect yourself.

Right to a Copy of this Notice. You have the right to a copy of this Notice which may be obtained by contacting the Privacy Officer.

For Further Information or Complaints. If you have questions, are concerned that your privacy rights have been violated, or disagree with a decision made about access to your PHI, you may contact our Privacy Officer who serves as the contact person for all issues related to the Privacy Rule. Complaints must be addressed to the attention of the Privacy Officer at Focus Mental Health Solutions, PLLC at 3016 West Charleston Blvd, Las Vegas, NV 89102; Telephone No. 702-790-2701. Written complaints may also be filed with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue SW, Washington, D.C. 20201. Complaints must name the practice, describe the acts or omissions that are the subject of the complaint, and must be filed within 180 days of the time you became aware or should have become aware of the violation. We will not retaliate or take any adverse action against you if you file a complaint.