M&A McKenzie & Associates
Counseling Services

110 S. Main St. Ste. 500
Wichita, KS 67202

316-351-7644 Phone
316-351-7689 Fax

Informed Consent & Therapy Contract

We feel it is important that, as our client, you are fully informed about the services you will be receiving. Your signature below indicates that you have received, read, and understand the practice policies of this agency in helping you make an informed decision about entering a therapeutic relationship.

Who Are We?

My therapist is associated with McKenzie & Associates LLC. I understand that my therapist is currently licensed by the state of Kansas Behavioral Sciences Regulatory Board and bound by the code of ethics for his or her profession: AAMFT Code of Ethics for Licensed Marriage & Family Therapist.

What Are the Fees?

My therapist's standard fee is $200 for an intake and $175 per clinical session. If I am not able to pay this fee for service, my therapist can discuss payment arrangements, and proof of my income will be required. I understand I am expected to pay at each session I attend, and if I am not able to pay at the session, I agree to discuss this with my therapist before the session begins.

What Is a Psycho-therapist?

A psychotherapist is an individual who has been trained to provide therapy from a systems perspective using various models and psychodynamic, cognitive-behavioral, humanistic, and eclectic approaches.

Do you take insurance?

I may have health insurance my therapist may be unable to accept or be out of network. In the event my insurance is not accepted, or coverage is no longer available, I agree to pay in accordance to the above applicable fees. If my therapist can take my insurance, I will be responsible for paying any expense not covered unless otherwise stated by my clinician. It is my responsibility to notify my clinician about any changes in health insurance coverage.

Will you talk to my doctor?

My therapist is required to consult with my primary care physician to determine if there may be a medical condition or medication that is contributing to a mental disorder. To complete such a consultation, my therapist will request that I complete a release form. I also understand that I may waive this consultation.

Risk?

I understand that there can be risks and benefits associated with therapy, and I have discussed those with my therapist.

Does this work?

I will work together with my therapist to set goals that I want to accomplish when coming to therapy. This means I will decide what I want to accomplish by coming to therapy, and it is my responsibility to help my therapist to understand the best ways to be helpful.

What Is Confidential?

I understand that, except under specific circumstances mandated by law, communications with my therapist will remain confidential, as will any records regarding the consulting process unless I sign a release form. If more than one family member participates in a session, each family member must consent prior to the release of the file information. The client's family members are not entitled access to client information just because they are family. Additionally, video or audio recording may be used by the clinic for your quality or care.

Will You Ever Break Confidentiality?

Specific circumstances require my therapist to break confidentiality and report information obtained because of this process. Those circumstances exist when a.) The therapist believes a client may be in danger to him or herself or to others; b.) the therapist believes that a child, elderly, or a person with a disability may be subjected to abuse or neglect; or c.) when a court order exists that information regarding the therapy process be provided.

When am I done?

The relationship with my therapist is an important relationship. I understand that I may end my relationship with this therapist at any time and agree to discuss the termination of therapy at a regular session. I understand that my therapist will assume that I want to reach my goals. However, I understand if there is no session activity or phone contact recorded in my file for a period 3 weeks, my file will automatically be closed. I understand that, in most circumstances, my file can be re-opened upon completion of a new intake and payment of any balance due.

Client Name:	
Parent/Guardian Name:	
Client (or Parent/Guardian) Signature:	Date:
Clinician Signature:	Date:

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FAMILY INFORMATION

Today's Date: ______________________

Client's Information:

Legal First Name:	Legal Last Name:	Preferred Name:
Date Of Birth:	Gender: (Circle) Female/Male	Preferred Pronouns:

Address:	City & State:	Zip Code:

Home Phone:	Cell Phone:	Email Address (Optional):
Employer/School:	Occupation:	Social Security Number:

Marital Status:
Married Separated Divorced Widowed Single Co-Habiting

Spouse/Significant other - Full Name:	Spouse/Significant other - Date of Birth:	Email Address (Optional):

If Minor, Parent(s)/Guardian(s) Information:

Mother's/Guardian Full Name & DOB: DOB: / /	Father's/ Guardian Full Name & DOB: DOB: / /
Address (if different):	Address (if different):
City, State & Zip Code:	City, State & Zip Code:
Home/Cell Phone:	Home/Cell Phone:
Email Address (Optional):	Email Address (Optional):
Employer/School:	Employer/School:

Financial Responsible: Mother/Guardian Father/Guardian Other – Name: ____
Other – Address: ____
Other – Phone: ____

Emergency Contact:

Name:	Phone:	Relationship:

Permission to contact in emergency. (Please Initial Yes or No):
Yes ____________________ No ___________________

Referral Source:

Please list any additional people living with you below:

Name:	Relationship:	Date of Birth:	Workplace/School:	Soc. Sec. # (Optional):

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PREFERRED COMMUNICATION

McKenzie & Associates LLC has the ability to send text message/phone call and email reminders for appointments. Please indicate which method of contact is preferred below.

**Please check your preferred appointment reminder method below.*

_____ - Phone Number: ________________________________ **(Please list only 1 phone number)**

Select any of the options you prefer (Note: you may select both)

- ☐ Text Message Reminder
- ☐ Phone Call Reminder

_____ - Email: ____________________________________ **(Please list only 1 email address)**

Client Name: ____ DOB: _________________

Client (or Parent/Guardian) Signature: ______________________________ Date: _________________

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Authorization/Waiver of Medical Consultation

I understand that under the provisions of the KSA 65-6404 (b) (3) my clinician is required to consult with my primary care physician or psychiatrist to determine if there may be a medical condition or medication that may be causing or contributing to any signs of a mental disorder that she or he may have observed while working with me or my minor child(ren). In the event that I or my minor child(ren) do not have a primary care physician, I acknowledge that my clinician has recommended that I seek medical consultation.

Authorization/Waiver - **Please select one of the following:**

- ☐ I **DO** authorize McKenzie & Associates LLC to consult with my or my minor child(ren)'s primary care physician. (Please complete Primary Care Physician Information below.)
- ☐ I do **NOT** authorize and waive my rights to McKenzie & Associates LLC to consult with my or my minor child(ren)'s primary care physician.

Primary Care Physician Information:		
Clinic/Facility Name:	Physician Name:	
Clinic/Facility Address:		
City & State:	Zip Code:	Phone Number:

By signing below, I agree with the above decision made to McKenzie & Associates LLC to consult/not consult with my/my minor child(ren) primary care physician, and I am aware that this authorization/waiver will become part of my clinical record.

Client Name:	
Parent/Guardian Name:	
Client (or Parent/Guardian) Signature:	Date:
Clinician Signature:	Date:

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Minor Consent

This is to certify that the client noted below has the legal right, custody or guardianship to authorize the care, treatment, and counsel of the individual minor(s) listed below. I give consent for this/these individual minor(s) to receive individual and/or family therapy from the clinician indicated below.

Client Information -		
First Name:	Last Name:	Date of Birth:
Parent/Guardian Authorizing Minor Consent -		
First Name:	Last Name:	Relationship:

Client name:	Date:
Parent/Guardian Signature:	
Clinician Signature:	Date:

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Consent to Release Information to McKenzie & Associates LLC

I understand that my clinician may contact other clinicians working at McKenzie & Associates LLC (listed below) or that these clinicians may contact my clinician in order to document emergency line telephone calls or to provide clerical support in regard to my file. I understand the type of information exchanged would typically include but is not limited to 1) demographic information for appointment scheduling; 2) documentation in regard to emergency calls; 3) case consultation; or 4) audio/video recordings, at the discretion of the clinic (these may be used **by the clinic** but are **not** permitted to be used by the client).

I give consent for my clinician as indicated above to communicate with the agency staff listed below:

McKenzie & Associates LLC Staff

Client Information -		
First Name:	Last Name:	Date of Birth:
If Minor, Parent/Guardian Information -		
First Name:	Last Name:	Relationship:

This consent remains in effect until the termination of therapy unless revoked by me in writing at an earlier time.

I issue this authorization with knowledge of the contents of the material or communication and understanding of the consequences and do so voluntarily and free from duress or undue influence.

In accordance with federal regulation (42 CFR Part 2) which prohibits any further disclosure of this information, except with specific written consent of the person to whom it pertains, re-disclosure of this information is prohibited.

I hereby hold harmless the above-named practitioners from any liability relevant to the release of the confidential information or privileged communication. I agree to pay the associated fee as outlined under the "Patient Financial Responsibility" portion of these documents for the preparation of the information released.

Client Name:	
Parent/Guardian Name:	
Client (or Parent/Guardian) Signature:	Date:
Clinician Signature:	Date:

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Behavioral Health Symptom Checklist

Client Name:	Date of Birth:	Date Completed:

Check mark any of the following terms that apply to the client noted above. If you are unsure, please make a note and ask your clinician.

- ☐ Abandonment issues
- ☐ Adult child of an alcoholic
- ☐ Aggressive physical behavior towards others
- ☐ Alcohol use
- ☐ Anger issues
- ☐ Anorexia/Bulimia
- ☐ Anxiety/Tension
- ☐ Child problems
- ☐ Cognitive problems (understanding, concentrating, etc.)
- ☐ Conduct problems /disruptive behavior
- ☐ Decreased appetite
- ☐ Delusions
- ☐ Depression
- ☐ Eating problems/concerns
- ☐ Fatigue
- ☐ Feelings of guilt/shame
- ☐ Feelings of hopelessness
- ☐ Financial problems
- ☐ Fire setting
- ☐ Grief/loss issues
- ☐ Hallucination
- ☐ Health concerns
- ☐ Homicidal thoughts
- ☐ Hyperactive/impulsive behavior
- ☐ Illegal drug use
- ☐ Insomnia
- ☐ Irritability
- ☐ Legal problems
- ☐ Mania
- ☐ Spouse/ex-spouse/significant other issues
- ☐ Mood swings
- ☐ Obsessive/Compulsive behaviors
- ☐ Pain
- ☐ Panic attacks
- ☐ Paranoia
- ☐ Parent-child conflicts
- ☐ Peer relationship conflicts
- ☐ Phobias
- ☐ Prescription or over-the-counter drug misuse/abuse
- ☐ Racing thoughts
- ☐ Seasonal depression (SAD)
- ☐ School problems
- ☐ Self-mutilation
- ☐ Sexual problems
- ☐ Sleep problems
- ☐ Social isolation
- ☐ Suicidal thoughts
- ☐ Tearfulness
- ☐ Weight loss/gain (significant)
- ☐ Work problems
- ☐ Other: ______________________________

List of all medications you are taking:

Medication	Dosage	Prescribed by	Date Started	What for?

List any counseling or therapy you or your family are receiving or have received:

____

If applicable, list your current primary care physician (DO, MD, ARNP, etc.):

____

Please briefly describe what brings you to therapy at this time:

____

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Consent to Release Information to Health Insurance Provider

I understand my clinician may contact my health insurance provider (listed below) or my health insurance provider may contact my clinician to obtain information necessary to verify my claim for reimbursement to me or my clinician. I understand the type of information requested would typically include but is not limited to: 1) the date of service; 2) the nature of service provided, or 3) the individuals who received the service. It may also include a diagnosis and treatment plan information.

I give consent for my clinician as indicated above to communicate with my Health Insurance Provider.

NOTE You are not required to use your Insurance Provider for services received. However, if you do **NOT** want to use your insurance provider, you will be charged for the full amount ($200 for the Intake session & $175 per session after Intake).

Health Insurance Provider:			
Street:	City:	State:	Zip:
Phone:	Fax:		
Group#:	ID/ACCT #:		
Health Insurance Provider :			
Street:	City:	State:	Zip:
Phone:	Fax:		
Group#:	ID/ACCT #:		

Client Authorizing Release:

Name:			
Street:	City:	State:	Zip:
Phone:	Date of Birth:	SSN:	

This consent expires one year from the date noted below unless revoked by me in writing at an earlier time. I issue this authorization with knowledge of the content of the material or communication and understanding of the consequences and do so voluntarily and free from duress or undue influence. In accordance with federal regulations (42 CFT Part 2) which prohibits any further disclosure of this information, except with specific written consent of the person to whom it pertains, re-disclosure of this information is prohibited.

Client Name:	
Parent/Guardian Name:	
Client (or Parent/Guardian) Signature:	Date:
Clinician Signature:	Date:

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PATIENT FINANCIAL RESPONSIBILITIES

Please ***initial*** *each line indicating your understanding and sign the bottom with today's date.*

_____1. If you have insurance, at the beginning of your calendar year, which for most people is usually January 1st, you may be required to pay a deductible. This means there is a certain amount of money that must be paid by you before your insurance company will pay for any service. It is YOUR RESONSIBILITY, not our responsibility, to make sure that you understand your deductible. **If you have a deductible, you will be required to pay it.** This could result in charges of $175 per visit until your deductible is met. IF you cannot afford these charges, your clinician may be willing to make a payment plan for you. However, all deductibles must be paid during the calendar year.

_____2. Please be up front about your deductible or lack of coverage. Should you choose not to disclose your lack of coverage and receive services anyway, you will be required to pay all charges encountered before future service will be rendered. We reserve the right to administratively close your file should you incur charges without disclosure of insurance information.

_____3. If you have insurance, you have an obligation to notify us and allow us to use the benefits. If you do not want your insurance to be used, this is your right, but you will also be obligated to pay 100% of the session fee (which is $175). It is **unethical and illegal** for us to give a client a sliding scale fee simply because they do not want to use insurance.

_____4. Our office does not bill for service. You are required to pay at the time service is rendered. If this is not possible, please discuss this ***before*** services are rendered.

_____5. Your account may be sent to **Collections** if no payments are received and/or no payment arrangements are made. You will be mailed statements, 1st and Final letter notices of your account being sent to collections prior to McKenzie & Associates LLC sending your outstanding balance to our collection agency.

FEES FOR THIRD PARTY COMMUNICATIONS

Communication between clinicians and other treating professionals is free of charge. However, communications with others may involve a fee.

_____1. Written reports to an attorney, court system, or limited case manager are billed at the rate of $175 per hour. These fees are not covered by insurance.

_____2. Phone consultations with attorneys, limited case managers, or legal representatives are billed at the rate of $175 per hour and broken down into 15 min increments. These fees are not covered by insurance.

_____3. In-person testimony will be billed at the rate of $200 per hour with a three-hour minimum charge. These fees are not covered by insurance. A minimum of $300 is required as a retainer, with the remaining fees due within 30 days.

_____4. Being served with a subpoena does not "excuse" the client from fees. Refusing to pay for testimony and serving a subpoena anyway will result in your file being administratively closed and a referral being made to a different clinician.

FEES FOR TELEPHONE AND EMAIL COMMUNICATIONS

_____1. Clinicians understand the need for an occasional email or telephone call. However, excessive requests via email, or excessive voicemails regarding anxiety-driven responses are not appropriate ways to resolve these issues. "Excessive" would be more than once a day, or several times a week when a client is not in crisis. Should your clinician not agree that a crisis is occurring, you may be billed.

Client Name: ___________________________________| Client (2) Name: ______________________________________

Client (or Parent/Guardian) Signature: ____Date: _________________

Clinician Signature: ____ Date: _________________

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Credit Card Information:
Card Type: __Master Card __VISA __Discover __AMEX Other:
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy):
Cardholder Zip code (from CC billing address):
3-digit code on back of card:
Email Address:

I, _____________________________, authorize Mckenzie & Associates to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

**Due to the changing times with COVID and increase utilization of telehealth services, we are updating our payment policy and so, as standard policy, we are now asking all clients to keep a card on file. This will be to cover copays and deductibles due at the time of service. We will discuss payments prior to the initial intake session so payment due will be known. If for some reason you need to postpone payment, change the card on file, or want to pay in person, please inform the office prior to the scheduled session.

Late fees: Typically, we will allow one no call/no show or late cancellation (under 24 hours). Anything after that will result in a $75 no call/no show or late cancellation fee. The card on file will be charged for this fee unless something has been discussed with your clinician and the office informed.

______________________________________ ___________________________

Customer Signature Date

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Cancellations, Emergencies, Service Policies, and HIPAA

Acknowledgement of Cancellation Policy:

Please be aware that your therapist will hold an appointment for you. If you no-show your therapist or cancel your appointment with less than a 24Hr. notice or no notice, your therapist may choose to process your readiness for therapy with you. Should problems with attendance occur, your therapist reserves the right to refer you to a different clinician. If keeping regularly scheduled appointments is a challenge for you, please discuss strategies with your therapist that McKenzie & Associates LLC can offer you to help you remember and keep appointments. If you do not schedule an appointment with your therapist after a missed appointment after 3 weeks of no contact, your file may be automatically closed. Should you wish to reopen it, you will be subject to the same procedures as any client opening a new file, including changes in session rate or lack of availability of your therapist to take new clients if his or her caseload is full. If you no-show your standing appointment, it will be assumed that you will attend the following standing appointment. We ask that you contact your therapist to confirm or reschedule.

Commercial/Self Pay Clients: If your therapist finds it necessary, you will be asked to pay a no-show/late cancel fee of $75 before you return for your next appointment.

Kancare/Medicaid Clients: If your therapist finds it necessary, you will be asked to schedule future appointments the same day; it is your responsibility to call and verify if your therapist has any available times.

Before/After Hours Cancellations: If you no -show/late cancel an appointment that is scheduled before/after regular business hours, you may not be able to reschedule future appointments outside of our regular business hour per your therapist's request. (Regular Business Hours: Mon-Fri. – 9:00 AM to 5:00 PM)

If you have questions about any of these policies, please consult with your therapist.

Acknowledgement of Emergency Policy:

If your life or safety is in danger, please call 911 or go to the nearest emergency room. You can call the office phone to leave a message. Be aware, however, that your clinician may not be able to return your call immediately, particularly after hours. Non-urgent concerns should be reserved for a scheduled appointment.

Service Policy:

If at any time you are unhappy with the services you are receiving or feel as if you are not benefiting from therapy, or if you are uncertain about the goals of treatment, please express your concerns to your clinician. If you would prefer, your clinician can also refer you to a different clinician. If your services can be improved in any way, please let your clinician know. It is important you understand your clinician is willing to help you meet your treatment goals, even if that means working with a different clinician.

HIPAA:

This notice of Privacy Practice describes how I may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical and mental health and related services.

By signing, I acknowledge that I have been informed of the procedures and policies above and have received a copy of the McKenzie & Associates LLC HIPPA privacy practices.

Client Name: ___________________________________| **Client (2) Name:** _____________________________________

Client (or Parent/Guardian) Signature: ____**Date:** _________________

Clinician Signature: ____ **Date:** _________________

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Authorization & Request of Confidential and Privileged Information

In accordance with my legal right to confidentiality and privileged communication relevant to the service that I have received, I authorize and request the disclosure of confidential information **from** McKenzie & Associates LLC clinician indicated below **to** the following individual or agency. Additionally, I authorize and request release of confidential information **from** the following individual or agency **to** McKenzie & Associates LLC.

Client Name: ____ **Client DOB:** __________________________
Therapist Name: ____

Authorize Release, To:
Name of Individual/Agency: ____
Relationship to client: ____
Address: ____ City: ____________________ State: ________ Zip: __________
Phone Number: _______________________ Fax Number: ______________________ Email: ____________________________________

Information that may be released:
_____ Mental Health Information (Diagnosis, Assessments, Treatment Plans, Summary)
(Initial)
_____ Verbal/Electronic Communication (face to face, phone call, video call, email, etc.)
(Initial)
_____ Scheduling Matters
(Initial)
_____ Billing Matters
(Initial)
____ Couples/Family Therapy (Authorization to participate in session(s))
(Initial)

By signing below, the client is releasing and authorizing:

- A summary report of services received by both the indicated clinician, as well as the agency and individual noted above.
- Consultations and/or verbal/electronic communication between the above-named parties.
- Any and all records pertaining to services received by the indicated clinician as well the agency or individual noted above.

It is my understanding that this information will be used for consultation and treatment purposes. This consent expires one year from the date noted below unless revoked by me in writing at an earlier time. I issue this authorization with knowledge of the contents of the material or communication and understanding of consequences and do so voluntarily and free from duress or undue influences. In accordance with Federal regulations (42 CFR Part 2) which prohibit any further disclosure of this information, except with specific written consent of the person to whom it pertains, re-disclosure of this information is prohibited. I hereby hold harmless the above-named practitioner from any liability relevant to the release of the confidential information or privileged communication. I agree to pay a reasonable fee for the preparation of the information released.

____ _____________________ _____________________________________
Client (or Guardian) Signature: **Date: (Expires in 1 year)** **Therapist/Clinician Signature:**

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Notice of Privacy Practices

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

This notice of Privacy Practice describes how I may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical and mental health and related services.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I, my office staff, and others outside of my office that are involved in your care and treatment may use or disclose your protected health information (PHI) for the purpose of providing health care services to you, to pay your health care bills, and to support the operation of my practice with your consent.

Treatment: I may use and disclose your protected health information to provide, coordinate, or manage your health care and other services related to your health care. This includes the coordination or management of your health care with a third party. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychotherapist.

Payment: Your protected health information may be used, as needed, to obtain payment for your health care services. Examples of payment are when I disclose your protected health information to your health insurer to obtain reimbursement or to determine eligibility coverage.

Health Care Operations: I may use or disclose, as needed, your protected health information in order to support the activities that relate to the performance and operation of my practice. Examples of healthcare operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

II. Uses and Disclosures Requiring Authorization:

I may use or disclose protected health information for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when I am asked for information purposes outside treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family therapy session, which I have kept separate from the rest of your medical record. These notes are given a greater level of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorized to the extent that (1) I have relied on that authorization, or (2) if the authorization was obtained as a condition of obtaining insurance coverage; law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose protected health information without your consent or authorization in the following circumstances:

- Child Abuse – If I have reason to suspect that a child has been injured as a result of physical, mental, or emotional abuse or neglect or sexual abuse, I must report the matter to the appropriate authorities as required by law.
- Adult and Domestic Abuse – If I have reasonable cause to believe that an adult is being abused, neglected, or exploited or is in need of protective services, I must report the belief to the appropriate authorities as requested by law.
- Health Oversight Activities – I may disclose protected health information to the Kansas Behavioral Sciences Regulatory Board if necessary for a proceeding before the Board.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

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- Serious Threat to health or Safety – If I believe that there is a substantial likelihood that you have threatened an identifiable person and that you are likely to act on that threat in the foreseeable future, I may disclose information in order to protect that individual. If I believe that you present an imminent risk of serious physical harm or death to yourself, I may disclose information in order to initiate hospitalization or to family members or others who might be able to protect you.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- *Right to Receive Confidential Communication by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of your protected health information by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another location.
- *Right to Request Restrictions* – You have the right to request that I not use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members who may be involved in your care.

  I am not required to agree to a restriction that you may request. If I believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy of your personal health information. Under federal law, however, you may not inspect a copy of the following records: psychotherapy notes, information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* - You have the right to request the right to an amendment of protected health information for as long as the information is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to Accounting* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- I am required by law to maintain the privacy of your protected health information and to provide you with a notice of my legal duties and privacy practices with respect to your protected health information.
- I reserve the right to change the privacy policies and practices described in the notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedure, I will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

V. Complaints:

If you are concerned that I have violated your privacy rights or disagree with a decision I made about access to your records, you may file a complaint with me or my office manager.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

This notice was published and becomes effective on/or before April 14, 2003.